

STATE OF OREGON

OREGON HEALTH AUTHORITY

OREGON STATE MEDICAID

**HEALTH INFORMATION TECHNOLOGY PLAN
(SMHP)**

Version 5

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Health
Oregon
Authority

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2	3/21/2013	Annual Update
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INTRODUCTION

Oregon has a history of innovation in health care delivery, access, and technology, dating back to its groundbreaking Medicaid waiver with the implementation of the Oregon Health Plan in 1994. The Oregon legislature also approved an ambitious health reform law (House Bill 2009) in 2009 and approved the implementation plan for Oregon's broad health care transformation in 2011 and 2012.

The year 2012 also saw the federal approval of Oregon's extraordinary 1115 waiver authorizing system-wide changes in Oregon's delivery of Medicaid services. In 2012, more than 600,000 Medicaid enrollees transitioned into new Coordinated Care Organizations (CCOs),¹ which provide integrated and coordinated physical, behavioral, and oral health care to just over 90 percent of Oregon's Medicaid population.² With the 2013 award of a Centers for Medicare & Medicaid Innovation (CMMI) State Innovation Model (SIM) grant, the Oregon Health Authority (OHA) seeks to accelerate, test, and spread innovations across the state, beyond Medicaid to improve the health outcomes, quality of care, and achieve sustainable healthcare cost growth for all Oregonians.

Now, in February 2014, the massive changes of 2011 and 2012 are behind us. The need for health information technology (HIT) to support and accelerate Oregon's health reform efforts is more pressing than ever before. Critical HIT infrastructure, programs and policies are needed at the local and State levels to support:

- The adoption and Meaningful Use of electronic health records (EHRs);
- The sharing of meaningful, reliable, actionable patient information for care coordination and care delivery; and
- The use of aggregated data, including clinical outcomes data – health systems, CCOs, health plans, State programs, and providers need to be able to use aggregated data to improve quality of care, target care coordination resources, and design new payment models.

Further, OHA, the single state Medicaid agency, has begun engaging with providers electronically around shared clinical information, transitioning from a fax- and paper-based operating environment into an HIT-enabled, electronic one.

OHA is reinforcing its goals of EHR adoption, Meaningful Use, and use of HIT and health information exchange (HIE) in a number of ways. Oregon's CCOs are eligible for substantial quality incentive payments linked to 17 metrics, including three Meaningful Use clinical quality metrics and one metric related to EHR adoption. Oregon's Patient-Centered Primary Care Homes (PCPCH, Oregon's medical home model) receive tier-rankings based, in part, on their achievement of Meaningful Use. CCOs and Oregon's Public Employees' Benefits Board (PEBB)

¹ For the reader's convenience, a list of acronyms used in this SMHP-U is attached as Appendix F.

² Additional information about the waiver can be found here: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>. Information about CCOs, including quarterly progress reports, can be found here: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>.

health plans have contract parameters that outline the role they must play in facilitating EHR adoption, Meaningful Use, and the use of HIE.

Vision highlights

The vision for Oregon's transformed health system includes statewide HIT/HIE efforts that ensure all Oregonians have access to "HIT-optimized" health care. "HIT-optimized" health care is more than the replacement of paper with electronic or mobile technology. It includes changes in workflow to assure providers fully benefit from timely access to clinical and other patient information that will allow them to provide individual/family-centric care. In an "HIT-optimized" health care system:

- Individuals have meaningful and timely access to their personal health information and are encouraged and empowered to engage in achieving positive health outcomes.
- Providers coordinate and deliver "whole person" care informed by meaningful, reliable, actionable patient information.
- Systems (health systems, health plans, CCOs) are supported in efficiently and effectively using aggregated data for comparability for quality improvement, population management and to incent value and health outcomes.
- Policymakers leverage and utilize aggregated data to provide transparency into the health and quality of care in the state and to inform policy development.
- All use HIT to realize the Triple-Aim of better health outcomes, better quality care, and lower costs.

To create an "HIT-optimized," individual-centric health ecosystem, the State has a role, as do CCOs, health plans, health systems, community and organizational HIEs, providers and individuals. For example, State HIT/HIE efforts can provide the right level of statewide technology, policies and operational guidance to ensure interoperability, privacy, security and accountability.

At a December 2013 CCO Summit, several CCO executives reflected on the impact of an "HIT-optimized" health care system in Oregon:

- "We have one provider who is both a physical and behavioral health provider, and never till now was able to get data from both sides of her practice into one tool on a patient. The Oregon legislative provisions requiring sharing of information were key to this." (Janet Meyer, Health Share of Oregon)
- "Investing in Jefferson HIE is important. The number one frustration of our case managers is the wasted duplication of services and tests." (Bill Guest, Cascade Health Alliance)
- "Jefferson HIE helps doctors and hospitals see more information about the patient." (Jennifer Lind, Jackson Care Connect)
- "Having an integrated shared care plan will transform care coordination." (Terry Coplin, Trillium Community Health Plan)
- "We are moving to using technology as a foundation to make decisions about care." (Phil Greenhill, Western Oregon Advanced Health)

As part of this larger health system transformation set of efforts, OHA is committed to advancing the meaningful use of health information through HIT and HIE to advance the Triple Aim of better health, better care and lower costs.

This SMHP-U sets out Oregon's strategies to accomplish those goals, from the beginning of 2014 through the end of 2018. After working closely with stakeholders, OHA has chosen a phased approach, with each phase described in greater detail below. Phase 1.0 encompasses the "as-is" landscape and includes efforts implemented as of 2013. Efforts planned for the near-term fall within Phase 1.5, which will be developed in 2014 and 2015. As Phase 1.5 nears completion, Phase 2 will begin, starting in 2015 and extending through 2018 or beyond.

SECTION A: THE STATE'S "AS-IS" HIT LANDSCAPE

- 1. WHAT IS THE CURRENT EXTENT OF EHR ADOPTION BY PRACTITIONERS AND BY HOSPITALS? HOW RECENT IS THIS DATA? DOES IT PROVIDE SPECIFICITY ABOUT THE TYPES OF EHRs IN USE BY THE STATE'S PROVIDERS? IS IT SPECIFIC TO JUST MEDICAID OR AN ASSESSMENT OF OVERALL STATEWIDE USE OF EHRs? DOES THE SMA HAVE DATA OR ESTIMATES ON ELIGIBLE PROVIDERS BROKEN OUT BY TYPES OF PROVIDER? DOES THE SMA HAVE DATA ON EHR ADOPTION BY TYPES OF PROVIDER (E.G. CHILDREN'S HOSPITALS, ACUTE CARE HOSPITALS, PEDIATRICIANS, NURSE PRACTITIONERS, ETC.)?**

OHA's most detailed, current information about EHR adoption—including break-downs by provider type and types of EHRs in use—is specific to incentive program participants. That information is laid out in a series of tables below. For other providers, information about past environmental scans and related information is set out in Appendix D. OHA's projections of future participation in the Medicaid EHR Incentive Program can be found in Section E.

EHR Adoption as reflected in incentive payments as of the end of FFY 2013

The information about EHR adoption among Medicaid providers is derived from Oregon Medicaid EHR Incentive Program data. As context for the information below, Oregon has a total of 15,017 actively licensed physicians, nurse practitioners, and dentists.³ A large majority of Oregon providers serve Medicaid patients. According to 2012 survey data, 85.0% of Oregon physicians accept new Medicaid patients with no or some limitations, and 81.7% of physicians have Medicaid patients.

Still, many Oregon providers do not meet the Medicaid patient volume threshold that is required to be eligible to receive Medicaid EHR incentive payments. Providers in Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) can assess their "needy individual" patient volume – including Medicaid, Children's Health Insurance Program (CHIP), sliding scale care and uncompensated care. All other providers must count Medicaid patients only (not including CHIP). For pediatricians, a minimum of 20% of patients must be Medicaid patients, depending on the practice setting. For all other eligible professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants in FQHCs/RHCs led by a physician assistant), a minimum of 30% of patients must be Medicaid and/or needy individual patients, depending on the practice setting.

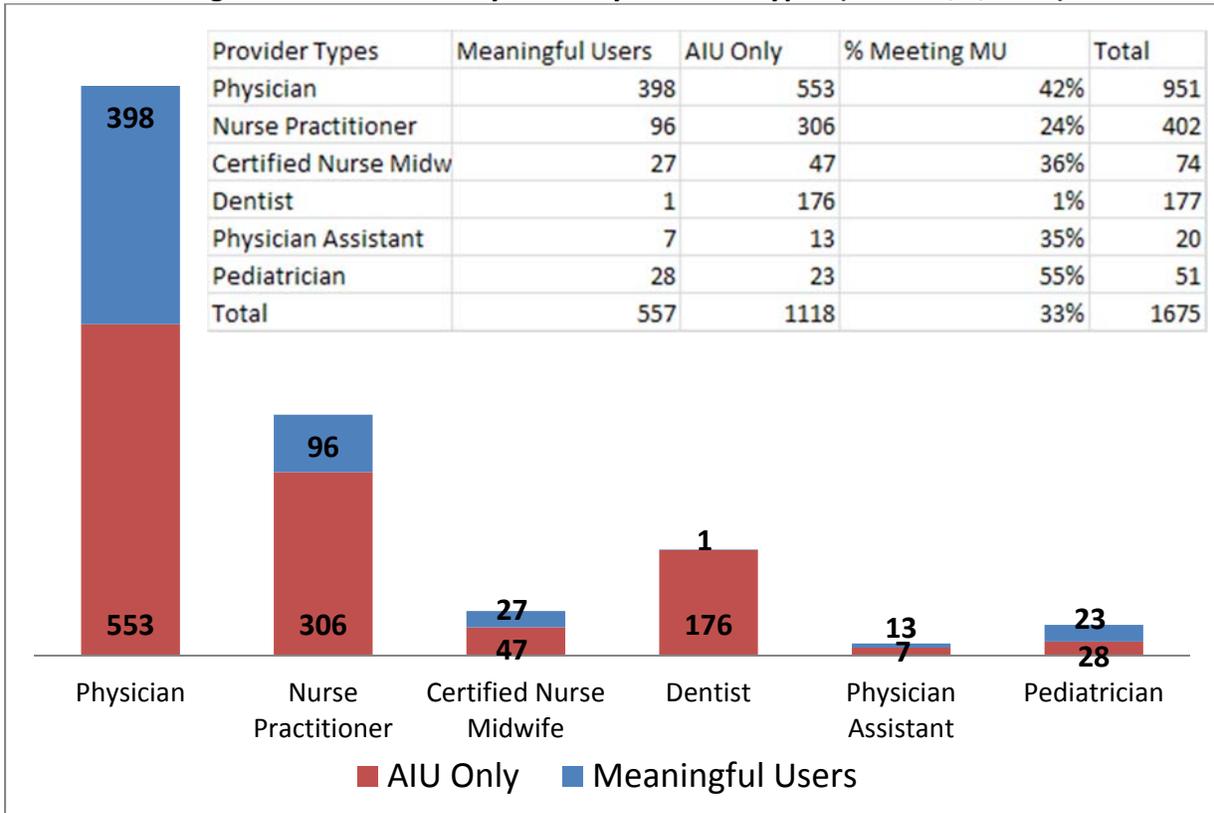
The state has seen strong growth in EHR adoption and Meaningful Use, as shown by the tables below.

³ Oregon Health Professions: Occupational and County Profiles, February 2013, <http://www.oregonhwi.org/resources/documents/2012ProfilesReportFINAL1.pdf>.

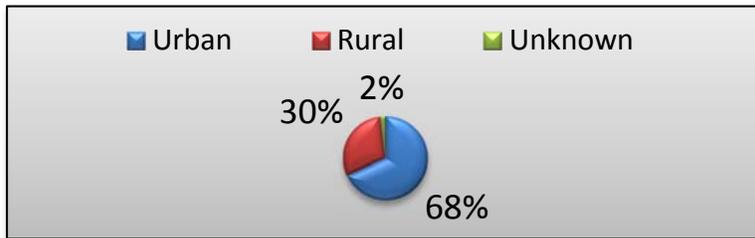
**Medicaid EHR Incentive Payments (AIU and MU):
FFY 2012 and 2013 Actual Payments**

Medicaid EHR Incentive Payments	FFY 2012	FFY 2013	Total
Total Eligible Professionals (at full rate)	\$22,043,348	\$16,697,928	\$38,741,276
Total Pediatricians		\$34,000	\$34,000
Total Eligible Hospitals	\$30,689,200	\$13,891,524	\$44,580,724
TOTAL	\$52,732,548	\$30,623,452	\$83,356,000

Oregon EHR Incentive Payments by Provider Types (as of 12/5/2013)



**Medicaid EHR Incentive Payments to EPs – Breakdown between *Urban and Rural*
Oct 2011 – Dec 2013**



2014 Certified EHR technology and Stage 2 MU

Oregon providers are using a variety of certified EHRs to qualify for incentive payments. As of October 2013, there were 38 EHR systems certified for 2014 that also were certified for CQMs -

- 6 were certified for 9 CQMS, the minimum
- 25 were certified for 12-30 CQMs
- 7 were certified for all 64 (one was Athena, used in Oregon)

2011-2013 Oregon Medicaid EHR incentive payment recipients' EHRs, Cross-walked with 2014 certified EHR technology⁴

	AIU	MU	Total
Allscripts	45	24	69
AthenaClinicals	1	3	4
eclinicalWorks	22	0	22
EPIC	403	336	739
Greenway (Primesuite)	35	46	81
NextGen	128	53	181
SuccessEHS	1	0	1
Total	635	462	1097

Oregon payment data from 10/2011 through 12/5/2013 for EHR incentives: *Medicare and Medicaid*⁵

	Medicare		Medicaid		Total	
	# Payments	Amount Paid	# Payments	Amount Paid	# Payments	Amount Paid
Eligible Hospitals	36	\$56,133,116	71	\$46,453,532	107	\$102,586,648
Eligible Professionals	4,231	\$62,010,422	2238	\$39,897,276	6469	\$101,907,698
Totals	4,276	\$118,143,539	2309	\$86,350,808	6576	\$204,494,346

⁴ Source: <http://oncchpl.force.com/ehrcert>, October 2013; Medicaid EHR Incentive Program Payment data, Dec 2013

⁵ Medicare EHR Incentive Program data, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/October2013_PaymentsbyStatebyProgramandProvider.pdf.

Eligible Professional (EP) EHR Incentive Payments

Medicaid EHR Incentive Program				
	2011	2012	2013*	Total
1	912	588	178	1678
2		486	71	557
Total	912	1074	249	2235

* Still accepting applications for 2013.

Medicare EHR Incentive Program				
	2011	2012	2013*	Total
1	1194	1979	45	3218
2		993		993
Total	1194	2972	45	4211

* Still accepting applications for 2013.

Hospital EHR Incentive Payments

Medicaid EHR Incentive Program*				
	2011	2012	2013**	Total
1	30	19	1	50
2		10	12	22
Total	30	29	13	72

* Medicaid: hospitals participating in Oregon's Medicaid EHR Incentive Program may receive payments over 3 years

** Still processing applications for 2013

Medicare EHR Incentive Program*				
	2011	2012	2013**	Total
1	9	12	8	29
2		7		7
Total	9	19	8	36

* Medicare: hospitals may receive payments over 4 years - 3 years if first payment occurred in 2014

** Still processing applications for 2013

EHR adoption based on REC data (as of 8/22/13)

Oregon's REC, O-HITEC, works with 480 practices ranging in size from 1 to 400 providers. O-HITEC's grant progress is reflected in the table below.

O-HITEC: Grant Progress Report 8/22/2013

REC Membership Summary	Number	Percentage	National Average
Total Enrolled	2674		
Total Completed MU1	1503	61%	67%
<i>Milestones Achieved To Date:</i> ⁶			
MS1	2674	100%	
MS2	2674	100%	
MS3	1503	61%	

Planned landscape assessment/survey efforts

Oregon is preparing for contracts for landscape assessments/surveys of EHR adoption. In the winter of 2013/2014, Oregon expects to seek CMS approval of a contract for a landscape assessment focused on the needs of Medicaid eligible professional (EP) types and eligible hospitals (EHs) for technical assistance/outreach to support EHR adoption and Meaningful Use. That assessment will support development of work plans for technical assistance/outreach to address gaps.

In addition, in the winter of 2013/2014, many of the Medicaid Coordinated Care Organizations (CCOs) are taking surveys of the providers in their geographic area to determine EHR adoption, Meaningful Use, and HIT/HIE capacity. Once the data are collected and analyzed, additional information will be available.

2. TO WHAT EXTENT DOES BROADBAND INTERNET ACCESS POSE A CHALLENGE TO HIT/E IN THE STATE'S RURAL AREAS? DID THE STATE RECEIVE ANY BROADBAND GRANTS?

The Oregon Health Network (OHN), which is now a part of OCHIN, is a non-profit, membership-based organization that was created in 2007 after the organization was awarded a \$20.2 million federal subsidy through the Federal Communications Commission (FCC) Rural Health Care Pilot Program (RHCPP). As of October 2013, OHN had more than 229 provider participants, including 46 hospitals. OHN's federal FCC subsidy is for deploying middle and final mile connectivity to infrastructures across Oregon, focusing on rural areas. Oregon is actively building broadband networks around the state with the assistance of federal funds.

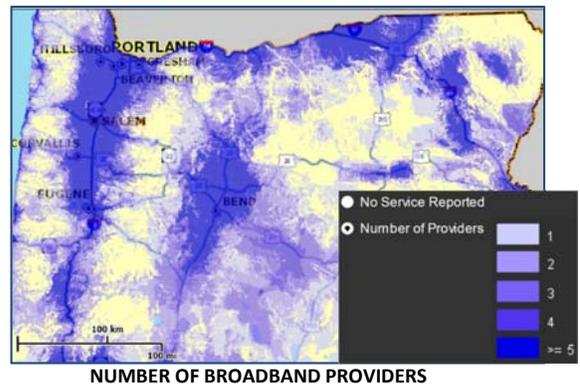
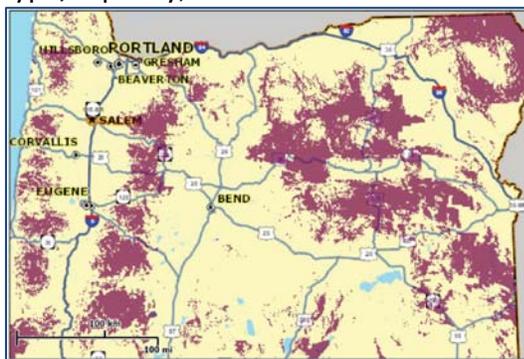
⁶ ONC's REC program has a performance-based reimbursement structure that compensates REC grantees for assisting primary care providers through three milestones: (1) a health care provider enrolls to receive assistance from a REC; (2) the provider "goes live" with an EHR that has e-prescribing and quality reporting functionalities enabled; and (3) the provider or REC attests that the provider has met the Medicare and Medicaid EHR Incentive Program criteria for Meaningful Use of an EHR.

Access to broadband technology

Oregon has a strong commitment to expand broadband access to all regions of the state. Oregon has significant geographic diversity, including highly urban, rural and remote areas, each with highly varying degrees of HIT capabilities. Broadband access is a critical element of the Strategic and Operational Plans for HIE.⁷

In November 2010, the Oregon Broadband Advisory Council submitted a report to the House Sustainability and Economic Development Committee for the Oregon Legislature, which responds to a congressional mandate for a national map and is used for an Oregon-specific map. These maps show where the state's broadband Internet services are located, and what speeds and types of service are being used. This initiative helps inform State HIT efforts regarding availability of broadband services among Oregon's acute care hospitals and critical access hospitals, rural health centers and FQHCs, among others. This information provides a basis for evaluation and planning efforts regarding broadband Internet access and service levels at hundreds of locations and communities throughout Oregon.⁸

The Oregon Health Network (OHN) Interactive Community Map⁹ currently shows all live OHN member sites, including facility type, address, telecom vendor, installation date, broadband type/capacity, and more.



Oregon is highly ranked in service availability for a large western state with a relatively small population, but broadband is not ubiquitously available across the state. The U.S. Department of Commerce reported in its February 2010 publication, *Digital Nation: 21st Century America's Progress Toward Universal Broadband Internet Access*, Oregon ranks eighth out of the 50 states for broadband reach based on household access to a fast internet connection.¹¹ Despite Oregon's favorable ranking in relation to other states, there are still business locations,

⁷ Oregon Broadband Advisory Council, Broadband in Oregon report to the Oregon Legislature, November 1, 2010, p. 3. <http://library.state.or.us/repository/2013/201304020755592/2010.pdf>.

⁸ Oregon's HIE Strategic Plan, 2010, p. 63.

<http://www.oregon.gov/oha/OHPR/HITOC/Documents/SandOpPlans201008/HIESTrategicPlanOR.pdf>.

⁹ Oregon Health Network. <http://www.oregonhealthnet.org/content/ohn-interactive-community-map>

¹⁰ Oregon Broadband Mapping Project. <https://broadband.oregon.gov/StateMap/>

¹¹ Oregon Broadband Advisory Council, 2010 report, p. 4.

<http://library.state.or.us/repository/2013/201304020755592/2010.pdf>.

residences and communities with limited or no service available.¹² The Oregon Broadband Adoption Survey Report 2012 states that “availability of service is not generally seen as a barrier, except for those living in some communities along the Northwest Coast, in the Willamette Valley or Central Coast, Central Oregon, and South Central Oregon.”¹³

Broadband grants

Oregon-based projects for broadband infrastructure, utilization and mapping have received more than \$52 million in federal loan and grant funding awards under the ARRA, more than \$20 million of which has gone to building and developing broadband infrastructure.

The Oregon Health Network (OHN) is one of 62 FCC Rural Health Care Pilot Programs (RHCPPs) nationwide. OHN is Oregon’s only RHCPP and is responsible for building the first statewide broadband tele-health network in the state. The goal for the first phase of the organization is to connect 200 eligible RHCPP providers to the network and to each other. These include non-profit hospitals, clinics (rural, tribal, FQHC, mental health, etc.) and community colleges with health care education programs. The second phase will build out from that core broadband and provider footprint, expanding participation to all for-profit providers (and those not eligible for RHCPP funding). These non-eligible participants will include for-profit clinics, hospitals, long-term care and assisted living facilities, allied health/distance education, payers, pharmacies and government agencies.¹⁴

Through the FCC RHCPP, OHN requires stringent service-level agreements with approved contracted telecommunications vendors to bring the high-speed, high-quality, reliable broadband connectivity required to support current and future HIT and telemedicine services and applications to providers across the state. This is accomplished through the FCC’s open, competitive bidding process and providers have access to OHN’s central network operations center (NOC), which manages the network connections 24 hours a day and seven days a week.

OHN itself is funded from multiple public and private sources. The infrastructure that OHN is building is primarily funded by the \$20.2 million FCC-sponsored subsidy that pays 85% of all installation and service fees. OHN pays 15% for non-recurring fees, and participants are responsible for the remaining 15% of monthly recurring costs. Across the state, 66 sites are actively participating with OHN, 33 sites are being monitored by the NOC. These sites are mainly located on the coast and along the population dense corridor associated with Oregon’s major interstate highways.¹⁵

¹² Oregon Broadband Advisory Council, 2010 report, p. 3.

<http://library.state.or.us/repository/2013/201304020755592/2010.pdf>.

¹³ Oregon Broadband Adoption, Sept. 10, 2012. <http://www.oregon.gov/broadband/Pages/index.aspx>

¹⁴ Oregon’s HIE Strategic Plan, 2010, p. 63.

<http://www.oregon.gov/oha/OHPR/HITOC/Documents/SandOpPlans201008/HIEStrategicPlanOR.pdf>.

¹⁵ Oregon Broadband Advisory Council, 2010 report, p. 15-18.

<http://library.state.or.us/repository/2013/201304020755592/2010.pdf>.

Barriers to broadband adoption in healthcare include a lack of demonstrated benefits and return on investment and sustainable funding for implementation and ongoing operational overhead costs. Interoperability and quality broadband access are technological concerns. Provider-level barriers include provider knowledge of, access to, and comfort with HIT. Concerns at the health systems level include technological interoperability, credentialing and privileging, and the difficulty of complying with evolving federal rules.¹⁶

Together, the broadband infrastructure initiative and the broadband mapping initiative are providing ongoing information about infrastructure gaps and allowing the Oregon to find ways to overcome challenges in broadband access for rural areas. Ultimately the goal is to ensure that both the middle and last miles of Oregon's broadband infrastructure are built throughout the state. Over the next three to five years, all communities in Oregon should have access to broadband Internet, which will help support widespread health IT projects, facilitated by local and regional efforts; making certain that providers and patients can engage in electronic exchange of clinical information to improve and support patient centered health care delivery.¹⁷

3. DOES THE STATE HAVE FEDERALLY-QUALIFIED HEALTH CENTER NETWORKS THAT HAVE RECEIVED OR ARE RECEIVING HIT/EHR FUNDING FROM THE HEALTH RESOURCES SERVICES ADMINISTRATION (HRSA)? PLEASE DESCRIBE.

FQHCs, FQHC lookalikes and HIT grants

Oregon's 27 FQHCs and 2 FQHC look-alikes provide services in 153 sites throughout the state. Fifteen of the FQHCs are OCHIN members. Oregon's FQHCs have received some federal government and non-profit HIT grant funding.

Seventeen FQHCs in Oregon were awarded Capital Improvement Program (CIP) grants by the federal Health Resources and Services Agency (HRSA). These grants were made available via the American Recovery and Reinvestment Act of 2009 and provided funds to support construction, repair, renovation, and equipment purchases. Equipment purchases permitted include HIT systems and EHR-related enhancements for Community Health Centers. Total CIP funding to Oregon FQHCs was \$14.3 million.¹⁸

In August 2009, United Way awarded the Coalition of Community Clinics a Project Innovation Grant in the amount of \$36,000. This coalition included thirteen FQHC clinics in the Portland Metro area. The grant had three primary deliverables, one of which is the creation of an information technology plan for each of the eight community-sponsored clinics. These clinics have worked with OCHIN to develop a plan for adoption of an EPIC EHR system in most clinics.

¹⁶ Broadband report, p. 23-24.

¹⁷ Oregon HIE Strategic Plan, p. 63.

¹⁸ HRSA websites, accessed Jan. 28, 2011, including: Capital Improvement Program Announcement Number: HRSA-09-244 Date: May 1, 2009 (<http://bphc.hrsa.gov/recovery/cip/capitalimprovementguidance.pdf>), Oregon FQHC grantees and awards amounts from: <http://granteefind.hrsa.gov/> and matched to two customizable data warehouse reports accessed via <http://datawarehouse.hrsa.gov/customizereports.aspx>.

Rural health clinics

Oregon has 60 RHCs that operate throughout the state. Rural clinics have a broad range of capacity and demand for health IT. Of the 46 RHCs that responded to a 2007 survey, 63% report that they do not use or have electronic medical records.¹⁹ Thirty of the 46 RHC respondents were without EHRs, 11 reports planning to implement an EHR in the next year, 16 reports being unable to implement an EHR due to the prohibitive monetary cost, and nine list both prohibitive cost and time required as reasons for being unable to implement an EHR.

Safety net clinics supported by OCHIN and HRSA funding

EHR adoption rates by FQHCs and Community Based Health Centers (CBHCs) have been accelerated by OCHIN. Based on ONC data, 24 of the 26 (92%) HRSA funded FQHCs and look-alike organization in Oregon have worked with the REC.²⁰ OCHIN provides a comprehensive suite of products including practice management and EHR (Epic) services, panel and population management tools to member organizations.

As an Organized Health Care Arrangement (OHCA) under HIPAA with a single record per patient, OCHIN functions as an HIO among its member organizations. The OCHIN master patient index contains information on more than 400,000 Oregonians and 600,000 lives across California, Oregon and Washington. OCHIN also operates SafetyNetWest, a practice-based research network that solicits proposals and coordinates research projects involving safety-net populations.²¹

In 2007, OCHIN received three grants from HRSA totaling nearly \$3 million to support implementation of EHRs at health centers and in networks that link multiple health center grantees, and to help health center networks implement HIT other than electronic health records, such as electronic prescribing, physician order entry, personal health records, community health records, health information exchanges, and creating interoperability.²²

In December 2012, OCHIN was awarded a HRSA Bureau of Primary Health Care Health Center Controlled Network grant, which was aimed at three main goals:

- Support Electronic Health Record (EHR) installations for new member health centers;
- Help 37 existing health center members attain Meaningful Use (MU) requirements and register for federal and/or state provider incentive payments and

¹⁹ Oregon Health & Science University Office of Rural Health, Oregon Federally Certified Rural Health Clinics, 2008 Report, p. 39. This office recently completed a new survey of RHCs, and results are expected by spring 2011.

²⁰ Customer Relationship Management (CRM) Tool, maintained by the Office of Provider Adoption and Support (OPAS) at ONC, http://datawarehouse.hrsa.gov/Download_HCC_LookALikes.aspx

²¹ Oregon Health Authority and the Health Information Technology Oversight Council (HITOC), Health Information Exchange: A Strategic Plan for Oregon, August 23, 2010, p. 73. Available at: <http://www.oregon.gov/OHPPR/HITOC/Documents/SandOpPlans201008/HIEStrategicPlanOR.pdf>.

²² HRSA press release, "HRSA Awards \$31.4 Million to Expand Use of Health Information Technology at Health Centers, August 27, 2007.

- To make technical improvements to OCHIN’s Epic EHR to help participating centers improve clinical quality measures (diabetes, hypertension, Pap test) and achieve Patient Centered Medical Home (PCMH) or relevant recognition.

4. DOES THE STATE HAVE VETERANS ADMINISTRATION OR INDIAN HEALTH SERVICE CLINICAL FACILITIES THAT ARE OPERATING EHRs? PLEASE DESCRIBE.

EHR adoption for Tribal clinics

Oregon has 10 tribal and Indian Health Service (IHS) clinics. These facilities are often in rural and isolated communities, and provide health care services to an expansive geographic area. Five tribal clinics use the IHS EHR Resource and Patient Management System (RPMS), in providing patient care. They include the following: Warm Springs Health Center, Warm Springs OR (IHS); Western Oregon Health Center, Chemawa, OR (IHS); Cow Creek Health & Wellness Center, Roseburg, OR (tribal); Yellowhawk Tribal Health Center, Pendleton, OR (tribal); and Siletz Community Health Center, Siletz, OR (tribal).²³ Most tribal and IHS clinics in Oregon use the IHS RPMS EHR system. This system is certified through ONC.

OHA has worked informally with IHS and some of the tribal clinics to provide a resource as questions and issues arise. For example, OHA coordinates with IHS on communications to their providers on the EHR Incentive Program. As needed, OHA will initiate more structured processes to assure ongoing coordination.

EHR adoption for Veterans Administration Health Systems

The Veterans Administration (VA) operates the EHR systems VistA and My HealtheVet. The VA reported a 100% adoption rate in Oregon in Oregon’s 2006 Ambulatory EHR survey.²⁴

OHA has an ongoing relationship with the VA in Oregon. For example, a provider from the VA participated in a HITOC workgroup. In April 2013, OHA met with VA representatives to discuss a pilot with the Portland VA around Blue Button. OHA will continue to collaborate with the VA and explore opportunities to work together.

5. WHAT STAKEHOLDERS ARE ENGAGED IN ANY EXISTING HIT/E ACTIVITIES AND HOW WOULD THE EXTENT OF THEIR INVOLVEMENT BE CHARACTERIZED?

Oregon Health Information Technology Oversight Council (HITOC)

HITOC is a Governor-appointed, Senate-confirmed council established in 2009 by House Bill 2009 to provide coordination between public-private partnerships around HIT efforts and to oversee HIT efforts in Oregon. In addition, HITOC acts as an advisory group to the Oregon Health Authority (OHA) on HIT issues. The council is comprised of 11 voting members,

²³ US DHHS Indian Health Services, Indian Health Services Directory, January 2011. Also, “IHS EHR Graphical User Interface Deployment Status” website, updated Jan. 20, 2011, accessed Jan. 26, 2011.

http://www.ihs.gov/cio/ehr/index.cfm?module=gui_facilities

²⁴ Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2006, p. 3. Prepared by David M. Witter, Jr., Witter & Associates. Available at:

<http://www.oregon.gov/OHPPR/docs/OR2006EHRSurvey.pdf>

representing the public and private sectors, specifically reflecting the geographic diversity of Oregon, including health care consumers, providers, business and other key stakeholders.

Shortly after HITOC was established, OHA applied for the 4 year federal cooperative agreement for HIE from the Office of the National Coordinator for HIT (ONC). To meet the terms of the cooperative agreement, OHA used HITOC to engage in an intensive strategic planning effort to develop Oregon's HIE Cooperative Agreement Strategic and Operational Plans in 2010. (The most recent update to those plans is attached as Appendix C.)

An interdisciplinary strategic stakeholder workgroup met from January 2010 to May 2010 to inform the development of the HIE Strategic Plan. Three workgroups (Finance, Legal & Policy, and Technology), two advisory panels (Consumer Advisory and HIO Executive) and two ad hoc stakeholder groups (e-prescribe and laboratory) were formed and actively met to develop policy recommendations and implementation tasks as outlined in the HIE operational plan. More than 120 individuals representing 80 organizations were involved in this effort.

HITOC also held several large public forums to gather input on the draft strategic plan, including an HIO Summit in April 2010 attended by 60 people representing 40 organizations and a privacy and security public forum attended by more than 150 people in May 2010. HITOC held a series of public meetings across the state during June and July 2010 to gather input on the draft HIE Strategic Plan; more than 150 comments were received from more than 100 individuals and organizations.

Stakeholder engagement in development of State HIT/HIE Business Plan Framework

To support Oregon's "HIT-optimized" health system transformation, in 2013, OHA set out to establish a multi-year State HIT/HIE Business Plan Framework building off the work for Oregon's Strategic and Operational Plans (see Appendix C for 2013 update). The intent for this new Business Plan Framework was to assess the changing environment (including the advent of Medicaid Coordinated Care Organizations (CCOs) and Meaningful Use Stage 2 requirements) and adjust the strategic direction for Oregon's state-level HIT/HIE efforts. To do so, OHA began by seeking broad stakeholder input regarding the role of State HIT/HIE technology, policy and other efforts in supporting health system transformation and conducting stakeholder listening sessions.

During spring 2013, OHA embarked on a series of listening sessions with key stakeholders, including CCOs, health plans, providers, associations, State leadership, and representatives of statewide and regional healthcare groups. See Appendix A for the Business Plan Framework, which includes a list of organizations participating in these sessions and a summary of the listening session responses.²⁵

Health Information Technology (HIT) Task Force

²⁵ The full listening session report is available at http://healthit.oregon.gov/Initiatives/Documents/Stakeholder_ListeningSession_Summary_2013-08-25.pdf.

To build stakeholder input into the Business Plan Framework, in July and August of 2013, OHA sought nominations for the HIT Task Force. The Authority sought a diversity of stakeholders, including: health plans/payers, health systems, hospitals, providers, local HIE efforts, public sector, advocates/consumers and HITOC. The resulting 19-member Task Force met five times between September and November 2013, with some members also volunteering to participate in additional ad hoc meetings to inform staff work. The HIT Task Force took into consideration the earlier, extensive work of Oregon's HITOC, the current environment, and output gathered from stakeholder listening sessions. (See Appendix A for the Business Plan Framework, which provides a list of HIT Task Force members and charter.)

The Task Force considered straw models, along with the results of the listening sessions and prior recommendations of HITOC as a starting point for constructing their recommendations. The resulting framework provides a foundational document for OHA's efforts, as well as helps to set the basis for a work plan for the ongoing oversight and policy work of the State.

Information about the Task Force was shared in multiple ways. The Task Force meetings were public meetings, where public comment was solicited. Task Force materials were posted online.²⁶ In November 2013, OCHIN, the Oregon Health Network (OHN) and the Oregon Medical Association jointly sponsored a statewide conference for interested stakeholders in Portland, Oregon, where the Oregon's State Coordinator for HIT presented on the work of the HIT Task Force and the evolving State strategies.

HIT Advisory Group

OHA has also convened a CCO stakeholder HIT advisory group to guide OHA's implementation of near-term state-level HIT/HIE "Phase 1.5" services (started in October 2013). The focus of the HIT/HIE Phase 1.5 services are technology and technical assistance needs of Medicaid providers and CCOs to support their health system transformation efforts. OHA anticipates that additional participants, beyond Medicaid, will wish to use the Phase 1.5 services and will contribute to the financing and governance of those services over time. See Section A.9 for more detail on Phase 1.5 services.

Ongoing Oregon stakeholder input

From the beginning, the project team has worked with stakeholder groups to obtain input to guide Oregon's development on multiple areas of State discretion. Stakeholder groups included HITOC, in addition to key State executives, policy makers and State staff, members are representative of both large health systems and rural hospitals, health plans, tribal clinics, independent physician associations, business, and consumers. Strong support from Oregon Association of Hospitals and Health Systems (OAHHS), Oregon Medical Association, Medicaid managed care organizations, Medicaid dental care organizations, tribes, consumer groups, county and local health departments, and others was evident throughout the planning process. The project team continues to seek opportunities to meet with and present to these groups and their constituents, using these opportunities to share information about Oregon's Medicaid EHR Incentive Program as well as to solicit input on areas of State discretion.

²⁶ <http://healthit.oregon.gov/Initiatives/Pages/Task-Force.aspx>

6. DOES THE SMA HAVE HIT/E RELATIONSHIPS WITH OTHER ENTITIES? IF SO, WHAT IS THE NATURE (GOVERNANCE, FISCAL, GEOGRAPHIC SCOPE, ETC.) OF THESE ACTIVITIES?

The Office of Health Information Technology (OHIT) and State Coordinator for HIT are a part of the Oregon Health Authority (OHA), which is the single State Medicaid Agency; thus, the State HIE activities are under the auspices of the State Medicaid Agency (SMA). Oregon's HIE and Medicaid HIT planning teams are essentially merged under the auspices of the OHA's OHIT. OHIT staff collaborate with partners from programs in OHA and OHA's sister agency, the Department of Human Services, on such issues as physician outreach and communications, long-term care, behavioral health provider concerns, public health HIE/HIT initiatives, among others.

As laid out in the Business Plan Framework, currently OHA is responsible for the following roles:

- Providing public accountability and transparency into State efforts, including the CareAccord® program and the Medicaid EHR Incentive Program, through the stakeholder council, HITOC (see description of HITOC above in Section A.5).
- Operating the CareAccord® program in part directly and partly through a contracted vendor.
- Convening a CCO stakeholder HIT advisory group to guide implementation of Phase 1.5 services (started in October 2013).
- Establishing, documenting and operationalizing State policies related to HIT/HIE within federal and State parameters, including HIPAA and other federal regulatory requirements, such as 42 CFR Part 2.
- Managing the federal relationship with ONC for the ONC State HIE Cooperative Agreement and CMS for the EHR Incentive Program and HITECH activities, as well as assuring federal compliance.

OHIT leadership also coordinates closely with external entities including regular meetings with:

- Other major entities offering statewide HIT/HIE supports, including OCHIN (hosting EHRs for most Oregon FQHCs), O-HITEC (Oregon's Regional Extension Center), and Oregon Health Network (Oregon's FCC Broadband grant recipient);
- Community HIE efforts in Central Oregon, Southern Coast, Southern, and Gorge areas;
- Major health systems, health plans, provider groups, and related organizations including the Oregon Healthcare Leadership Council, Oregon Association of Hospitals and Health Systems, Oregon Medical Association, Oregon Health and Sciences University, Oregon Health Care Quality Corporation and others;
- Counties, public health and behavioral health associations, including the Oregon Coalition of Level Health Officials (CLHO) and the Association of Oregon Community Mental Health Programs (AOCMHP).

Emergency Department Information Exchange (EDIE)

OHA is participating in the governance and financing of public/private collaboration through the Oregon Health Leadership Council (OHLC) to bring the Emergency Department Information Exchange (EDIE) technology to all hospitals in Oregon in 2014. OHLC has formed a coalition of

all major stakeholders, including hospitals, health plans and emergency department (ED) physicians, who are committed to addressing the issue of overutilization of ED services through the implementation of a statewide technology solution. OHLC will coordinate the deployment of EDIE statewide in Oregon, in collaboration with OHA, the Oregon Chapter of the American College of Emergency Physicians, OHLC member health plans, and the Oregon Association of Hospitals and Health Systems. As of December 2013, all 59 hospitals in Oregon have agreed to implement EDIE in the next 12 months. Oregon hospitals and health systems (including Kaiser, Legacy, OHSU, PeaceHealth, Providence, and St. Charles) have signed attestations committing their organizations to implement the EDIE system within the next 12 months.

Through a grant, OHA contributed \$250,000 CMMI State Innovation Model (SIM) funding to the implementation and first year subscription costs of this initiative with the OHLC committing an additional \$150,000 and the OHLC member health plans another \$24,000. Individual hospitals and health systems will invest based on the size of their facility, category, and the number of ED visits experienced per year.

7. SPECIFICALLY, IF THERE ARE HEALTH INFORMATION EXCHANGE ORGANIZATIONS IN THE STATE, WHAT IS THEIR GOVERNANCE STRUCTURE AND IS THE SMA INVOLVED? HOW EXTENSIVE IS THEIR GEOGRAPHIC REACH AND SCOPE OF PARTICIPATION?

CareAccord® statewide health information exchange (HIE)

CareAccord® was developed and is operated by the Oregon Health Authority (OHA), which is the single State Medicaid Agency. OHA's vendors are Harris, as the systems integrator, and MirthMail. Development of CareAccord® was funded through an ONC State HIE Cooperative Agreement. In November 2013, CMS approved the use of MMIS operations and maintenance funding for ongoing operations of CareAccord®. (The CMS approval letter is Appendix G to this SMHP-U. For more information on Medicaid operations uses, please see Section A.8.)

CareAccord® serves providers across Oregon with Direct secure messaging. Currently, providers can use CareAccord® for communication with State staff—in OHA's Division of Medical Assistance Programs (DMAP) and Oregon Public Health Division (OPHD), for example—and additional opportunities will be developed. Because CareAccord® is Direct Trust accredited, users also can connect to users of other health information service providers (HISPs) that are part of Direct Trust community. In addition, Oregon is a member of the National Association for Trusted Exchange (NATE), so CareAccord® users can look up and connect to California and Alaska providers who use HISP services from other NATE members. (For additional information on NATE and Direct Trust, see Section A.13.)

Participants include ambulatory providers, long term care, dental clinics, imaging services, behavioral health, a CCO, and OHA Medicaid and public health programs. As of December 30, 2013, CareAccord® has 936 registered accounts for 116 Organizations. Other details of participation are reflected in the following tables.

CareAccord® Organizations by Types, as of December 31, 2013

Organizational Type	# of Organizations
Acute Care Hospitals	5
Ambulatory	79
Laboratories	3
Behavioral Health	14
Pharmacy	1
Dental	6
Medical Management	3
POLST registry	1
State Programs (includes Public Health, DMAP)	2
Hospice	1
CCO	1
Total	116

Local and organizational health information organizations (HIOs)

In Oregon, a number of local and organizational health information activities are supported by private, non-profit and public sector organizations. Local HIEs have developed across the state to facilitate exchange of patient information between providers. Some are organizational centric and some are community based. Significant “white space” exists due to geographic and/or service gaps.

Oregon’s existing health information activities are noteworthy for a number of reasons, including geographic coverage, types of services offered and level of support by community stakeholders. Some of these efforts are overseen by boards of directors or advisory groups comprised of local stakeholders, health care leaders and representatives of organizations who are involved or plan to participate in intrastate HIE; others are being managed primarily by the local hospital. By and large, local and organizational health information activities have organized with the mission to improve health care in each of their communities achieved through increased health IT adoption and HIE. Although these efforts share a common mission, they do vary in community history, selected technology, design and infrastructure, stage of development and demonstrated ability to exchange clinical data. The HIE Strategic Plan anticipated the expansion of connectivity by the local health information activities to include not only hospitals and affiliated providers, but also tribal clinics, FQHCs, RHCs, laboratories, pharmacies and other entities within the health care system.

- Bay Area Community Informatics Agency (BACIA):
 - Based out of Coos Bay, serving the Southern Oregon coast
 - Participants include: hospitals, labs, x-ray facilities, clinics

- Vendor: Medicity
 - Services: Community health record
- Central Oregon Health Information Exchange:
 - Based out of Bend, serving Central Oregon
 - Participants include: hospitals, labs, x-ray facilities, and the majority of clinics in the Bend area
 - Vendor: Relay Health
 - Services: Community health record
- Gorge Health Connect:
 - Based out of The Dalles, serving the greater Mid-Columbia River Gorge region, and supplying Jefferson HIE subscribers with Direct secure messaging services and referrals
 - Participants include: Mid-Columbia Medical Center and Clinics, North Central Public Health, Gorge Urology, Mid-Columbia Surgical Specialists. Gorge Health Connect currently serves 9 organizations and 32 providers.
 - Vendor: Medicity
 - Services: Direct secure messaging and referrals
- Jefferson Health Information Exchange (JHIE):
 - Based out of Medford, serving Southern Oregon
 - Participants include investments from all four CCOs in the region, Asante Health System, Providence Medford Medical Center, Sky Lakes Medical Center, Mid Rogue IPA and PrimeCare. JHIE currently serves 294 providers in 51 clinics/practices across Southern Oregon. Twenty seven additional clinics/practices are in the enrollment process and 139 new clinics are in the JHIE pipeline for enrollment in 2014.
 - Vendor: Medicity
 - Services: JHIE went live in January 2013 with Direct secure messaging and a closed-loop referral network where users of JHIE can send and receive clinical referrals and communicate with one another about the patient in a secure environment (Phase I). In 2014, JHIE will implement it “Phase II” functions to include
 - Patient search and discrete data (clinical reports and results) retrieval
 - EHR integration with JHIE will allow for one interface for all results and reports (including discrete data) to be delivered into the EHR from all participating data sources; EHR participants also will be able to send summary documents to JHIE as well as to other HIE participants via their EHR
 - Alerts will become available through JHIE from hospitals and urgent care facilities (e.g., emergency admit, discharge summaries, etc.) to support care coordination among providers and CCO care management teams.
- Organization HIEs:

- A number of the larger health systems in Oregon have built organizational HIEs. These solutions are often driven by business needs to establish laboratory or other referrals with community partners.
- EHR and HISPs for Direct secure messaging:
 - Oregon health systems, hospitals and providers seeking to meet Meaningful Use requirements are working now and over the next year or two to establish Direct secure messaging functionality within their EHRs by procuring HISP services.

Veterans

Connectivity with the Veterans Administration Medical Center in Portland and VA satellite clinics is expected to be accomplished through statewide Direct secure messaging, at a minimum, or possibly through local agreements with individual HIOs.

As described in Section B.2, the State expects to facilitate the exchange of clinical information with entities in the State, including Department of Defense installations located in various parts of the State via State-level enabling infrastructure.

8. PLEASE DESCRIBE THE ROLE OF THE MMIS IN THE SMA’S CURRENT HIT/E ENVIRONMENT. HAS THE STATE COORDINATED THEIR HIT PLAN WITH THEIR MITA TRANSITION PLANS AND IF SO, BRIEFLY DESCRIBE HOW.

MMIS

Oregon implemented a new MMIS in December 2008. The new MMIS replaced a 27-year-old system that used outdated technology and could not be updated to support increasingly complex State and federal requirements. The old system was built to process 260,000 claims per month for 116,000 eligible clients. In 2013, prior to the 2014 Medicaid expansion, Oregon's MMIS tracked approximately 660,000 participants and processed about 2.7 million claims, encounters and capitation transactions each month; the demand is increasing exponentially with the Medicaid expansion. Oregon’s MMIS system is currently certified by CMS. The MMIS and the Provider Web Portal are the backbone of the EHR Incentive Program.

MITA

The Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A) Advance Planning Document (APD) was approved by CMS in March 2011. The MITA Framework Version 2.0 and Business Process Model are the guiding documents for the State Self-Assessment. The MITA mission, goals and objectives are the guiding principles used to develop the tools necessary to transform the Oregon Medicaid enterprise and improve the administration of the Medicaid program.

Applying MITA principles broadly, Oregon believes that the MITA framework provides an approach that extends beyond the Medicaid program and creates a business reference model for Oregon’s Healthcare Enterprise. In the context of Oregon’s Medicaid EHR Incentive Program specifically, Oregon Health Authority (OHA) OHIT staff and MITA team have consistently collaborated and communicated since 2010; the foundation has been built to understand the

concepts and interdependencies. Oregon's Medicaid enterprise approach will continue to include collaboration between these two teams to in synergistic efforts. Oregon's Meaningful Use efforts have been incorporated into Oregon's MITA 3.0 SS-A, which is anticipated to be submitted to CMS anticipated in early 2014.

CareAccord®

OHA has expanded its MMIS enterprise, in compliance with the MITA and CMS Seven Standards and Conditions, to include ongoing operations of CareAccord®, Oregon's statewide health information exchange (HIE). (Please see Section A.7 for more information about services and participation.) CareAccord® supports the Medicaid enterprise with Direct secure messaging of patient clinical documentation relating to provider appeals and prior authorization.

Previously providers submitted documentation for prior authorization and appeals to OHA's Division of Medical Assistance Programs (DMAP) via fax and mail. Using CareAccord® Direct secure messaging in place of fax and mail leads to multiple benefits:

- It supports more timely and responsive service and reduces the risk of lost documentation, which can create barriers for Medicaid enrollees to access necessary services.
- It supports strong audit trails, as CareAccord® generates receipts when messages are sent, received and opened.
- It leverages CMS's investment in adoption and Meaningful Use of EHRs by Medicaid providers, particularly as Medicaid providers adopt EHRs that are certified to 2014 standards and are capable of exchanging information from within the EHR using the Direct protocol. As CareAccord® became EHNAC accredited for Direct Trust in October 2013, CareAccord® subscribers (including DMAP) are able to share messages across to other Direct Trust accredited Direct secure messaging providers (health information service providers (HISPs)).
- It leverages investment by the ONC in HIE. Providers across Oregon already are using CareAccord® Direct secure messaging to exchange information in a secure, HIPAA-compliant manner and have integrated Direct secure messaging in their clinic workflow. Using this same mechanism for Medicaid payment processes is efficient and reuses technology already available to providers.
- It moves Oregon's Medicaid operations towards more advanced levels of automation moving Oregon further along on the MITA scale for certain program areas.

Use of CareAccord® for Medicaid operations can be expected to advance MMIS objectives around:

- More accurate and timely claims processing,
- Reduction in program and administrative costs through more effective claims processing,
- Improved response time to provider inquiries regarding payment and prior authorization,
- Increased utilization of computer capability,

- Improved operational control and audit trails,
- Improved timeliness of exchange of documents for provider appeals.

Oregon has registered DMAP staff for CareAccord® accounts, so that CareAccord® can be used as a communication tool between DMAP and Medicaid providers for prior authorizations and appeals. After the DMAP prior authorizations and appeals hearings staff is fully trained, CareAccord® staff will carry out targeted outreach to the providers who most often communicate with those DMAP staff (the DMAP staff's trading partners). Targeted outreach includes increasing the providers' awareness that they can use Direct secure messaging to communicate with DMAP, setting up CareAccord® accounts and providing any needed training to support that use. Over time, OHA intends to expand the Medicaid use cases to improve other Medicaid and OHA administrative functions. MMIS funding for CareAccord® operations was approved in November 2013. (See Appendix G.)

9. WHAT STATE ACTIVITIES ARE CURRENTLY UNDERWAY OR IN THE PLANNING PHASE TO FACILITATE HIE AND EHR ADOPTION? WHAT ROLE DOES THE SMA PLAY? WHO ELSE IS CURRENTLY INVOLVED? FOR EXAMPLE, HOW ARE THE REGIONAL EXTENSION CENTERS (RECs) ASSISTING MEDICAID ELIGIBLE PROVIDERS TO IMPLEMENT EHR SYSTEMS AND ACHIEVE MEANINGFUL USE?

Context for State activities - Medicaid providers in Oregon

In Oregon, the vast majority of providers accept Medicaid patients. In fact, data validates that 85% of the physicians in the state are Medicaid providers. The Oregon Health Authority has conducted a dedicated physician workforce survey every two to three years since the early 2000s. The survey generates important information about physician attitudes and opinions, as well as demographics and practice characteristics. It has been a key data source for monitoring physician acceptance of Medicaid, Medicare, and commercial payment and, perhaps more importantly, reasons for non-acceptance when that is the case. The 2009 survey report, including methodology and a copy of the questionnaire, is available online here: http://www.oregon.gov/oha/OHPR/RSCH/docs/workforce/2009_physician_workforce_survey.pdf.

In 2012, the survey was very similar: a mixed-mode (electronic and mail) questionnaire sent to all actively licensed M.D.s and D.O.s practicing in Oregon. As in the past, physicians were asked to what extent their practices were accepting new Medicaid/Oregon Health Plan (OHP) patients. Response options were: no limitations – practice is open to all new Medicaid patients; open with limitations; and completely closed to all new Medicaid patients. 85% of physicians reported that their practice was accepting new Medicaid patients with no or some limitations. This figure is included in Oregon's quarterly reports to CMS, since it represents the baseline value for one of the 2012 waiver performance measures; see: <http://www.oregon.gov/oha/healthplan/DataReportsDocs/Third%20Quarter%202013.pdf> (page 41 of the PDF).

Promoting EHR adoption and Meaningful Use

One vital way the Oregon Health Authority (OHA) facilitates EHR adoption is by promoting and operating the Medicaid EHR Incentive Program, which launched in September 2011. As of November 26, 2013, approximately 1,675 eligible professionals (EPs) and 54 eligible hospitals (EHs) in Oregon had received Medicaid incentives, including 556 EPs who have been paid for Meaningful Use Stage 1. Of the 912 EPs who applied for an Adopt, Implement or Upgrade (AIU) payment in 2011, 53% returned for a Meaningful Use payment in 2012.

OHA is reinforcing its goals of EHR adoption, Meaningful Use, and use of HIT/HIE in a number of ways. For example, Patient-Centered Primary Care Homes (PCPCHs, Oregon's medical home model) receive tier-rankings based, in part; on their achievement of Meaningful Use (see Benchmarks in Section E.2). Medicaid Coordinated Care Organizations (CCOs) and Oregon's Public Employee Benefits Board (PEBB) health plans have contract parameters that outline the role they must play in facilitating EHR adoption, Meaningful Use, and the use of HIE.

CCOs are eligible for substantial quality incentive payments linked to 17 metrics, including three clinical quality metrics and one metric related to EHR adoption (see Benchmarks in Section E.2). CCOs, as a part of their contract to serve Medicaid enrollees, will be measured on EHR adoption. The improvement target approach looks at the increase in CCO providers who received incentives under either the Medicaid or Medicare EHR Incentive Programs using a program year 2011 baseline. CCOs are also required to promote and facilitate EHR adoption, Meaningful Use, and health information exchange amongst their providers.

OHA directly encourages EHR adoption and Meaningful Use. In addition to making information and guidance available via website, presentations, and materials, OHA has entered or plans to enter into contracts (as approved by CMS) for assistance with planning, strategy and communications as mechanisms to develop and implement strategies for facilitating EHR adoption. All of OHA's efforts around Phase 1.5 and Phase 2.0 services (described in greater detail below) encourage the adoption and Meaningful Use of EHRs. These efforts enhance the value of providers' HIT investments—and thus encourage providers to become meaningful users of EHRs—through services that include, but are not limited to,

- expanded technical assistance to Medicaid eligible professional (EP) types and eligible hospitals (EHs);
- health information service provider (HISP) integration to make it easier for providers to incorporate HIE into their EHR workflow;
- a clinical quality metrics registries (CQMR) for quality measures for Meaningful Use and CCO incentives;
- provider information repository services that simplify identifying and locating providers with provider contact information (including Direct secure messaging address), credentials, licensing information, affiliations and other information;
- electronic statewide hospital notifications alerting care teams when their patients are seen in the hospital; and
- an HIT/HIE compatibility program for connection to statewide HIT infrastructure, that includes national standards and sets baseline expectations for local, regional and

organizational HIT/HIE efforts to ensure interoperability, privacy and security, and facilitate sharing of information.

Regional Extension Center (REC): O-HITEC

As Oregon's Regional Extension Center, O-HITEC has worked with stakeholders throughout the state to provide education, outreach, and technical assistance, to help providers select, implement, and meaningfully use certified EHR technology to improve the quality and value of health care and meet the federal requirements for the Medicaid and Medicare EHR Incentive payments. O-HITEC received the federal ONC Regional Extension Center contract for Oregon. As of September 2013, O-HITEC had helped 2,674 eligible physicians and clinicians "go live" on approved EHRs, with 1,621 of those providers and clinicians achieving Stage 1 Meaningful Use requirements.

O-HITEC's ONC funding originally was scheduled to expire in February 2014. O-HITEC has applied for a no-cost extension to continue to provide services through February 2015, but no new funding is associated with the extension. Moreover, the ONC funding cannot be used to assist providers who are trying to attain Meaningful Use Stage 2. Nor can it be used to assist Medicaid specialists: The ONC funding is limited to assistance for primary care (internal medicine, family practice, OB/GYN or pediatrics) providers only.

Oregon's new HIT/HIE efforts underway: Phase 1.5

In addition to the Emergency Department Information Exchange (EDIE) initiative (see Section A.6) and the use of CareAccord® Direct secure messaging for Medicaid prior authorizations and appeals (see Section A.8), planning and preparation has begun to support Medicaid providers through the design, development and implementation of the following Phase 1.5 initiatives.

In collaboration with and support of all 16 CCOs, OHA is accelerating development of foundational and high-value services in 2013-2015 ("Phase 1.5"). The near-term statewide HIT/HIE priority elements were identified through the stakeholder process, including the listening sessions, conversations with the HITOC, and discussions with CCOs, health plans, providers and interested parties (see Section A.5) and are captured in the State Near-Term HIT/HIE Development Strategy document (Appendix B) and reflected in the overarching State HIT/HIE Business Plan Framework (Appendix A).

When OHA requests funding to support technology and implementation costs for Phase 1.5, OHA will address each element of Phase 1.5 and any needed cost allocation in the I-APD-U. The expected need for cost allocation is explained in greater detail in the description of each element that follows.

Development of state-level provider information repository services.

Oregon anticipates that the Medicaid enterprise will use provider information repository services for multiple purposes and that the services will benefit both Medicaid and non-Medicaid users. When OHA requests funding for the technology and implementation of these services, an appropriate cost allocation plan will be provided.

While multiple provider directories or databases exist in Oregon today, OHA plans to develop state-level provider information services that will serve as the central, authoritative source of information on key provider information. State-level provider services will leverage data existing in current provider databases and add critical new information and functions, such as HIE “addresses” for providers, and provider affiliation to practice settings. OHA will engage stakeholders through one or more workgroups on the scope of functions that will define the provider information services and the requirements to achieve those functions. State-level provider information services will:

- Create efficiencies for operations, analytics, oversight, and quality reporting for Medicaid and OHA programs, as well as for CCOs, local HIOs, and eventually for health plans, health systems, and providers.
- Include key provider information such as demographics, practice locations, specialty, licenses, and common core credentialing documentation.
- Support community, CCO, OHA and health plan analytics that rely on attributing providers to clinics.
- Enable the exchange of patient health information across different organizations and technologies.
- Enhance care coordination across disparate providers and around transitions of care by providing easy access to provider information.

Incremental development of a state-level patient/provider affiliation service.

Oregon anticipates that the Medicaid enterprise will use the patient/provider affiliation service for multiple purposes and that the service will benefit both Medicaid and non-Medicaid users. When OHA requests funding for the technology and implementation of this service, an appropriate cost allocation plan will be provided.

The patient/provider affiliation service will be a state-level resource that identifies key patient information as well as the patient’s primary care provider or clinic and covered CCO/health plan. The incremental development of a state-level patient/provider affiliation service will serve as a building block to facilitate the exchange of information, program operations including Oregon’s Patient-Centered Primary Care Home program, and analytics for Medicaid and OHA programs, as well as for CCOs, local HIOs, and eventually for health plans, health systems, and providers.

Statewide hospital notifications.

Oregon anticipates that notifications will benefit both Medicaid and non-Medicaid users. When OHA requests funding for the technology and implementation of notifications, an appropriate cost allocation plan will be included in the I-APD-U. As described in Section A.6, OHA is using SIM funds to support a grant to bring Emergency Department Information Exchange (EDIE) services to hospitals across Oregon. OHA anticipates that the partnership involved in EDIE may provide a model for fair share partnerships to support statewide hospital notifications.

Statewide hospital notifications will provide alerts to providers, health plans, CCOs and health systems when their patients are seen in emergency department or inpatient setting. Although hospital notifications are occurring in some local areas, statewide notifications bring this high value service around expensive transitions of care to all geographical areas and all care teams. Oregon hospitals and health plans are already investing in the Emergency Department Information Exchange (EDIE), with financial and governance participation from OHA (see Section A.6). Statewide notifications add the inpatient information and broadens access to ED information to care teams (including, for example, care coordinators and intensive behavioral health teams and crisis units), CCOs, and health plans. Additional use cases for notifications will be developed, and notifications services may expand to more care settings and address both emergent and non-emergent patient-care situations.

Statewide Direct secure messaging.

Oregon anticipates that some aspects of statewide Direct secure messaging will focus exclusively on Medicaid users. For example, a HISP integration pilot will serve Medicaid providers only. Other efforts are expected to extend beyond Medicaid uses. For example, a solution to translate computer-generated attachments would serve non-Medicaid needs as well as Medicaid needs. At this point, OHA plans to request HITECH funding to support planning and preparation for statewide Direct secure messaging. If OHA requests HITECH funding for the technology and implementation of these services, an appropriate cost allocation plan for each service will be provided.

Statewide Direct secure messaging will augment local capabilities, add new members of the health care team, and support statewide connections between providers from within their EHR to provide electronic connectivity of all members of the care team across organizational and technological boundaries. State activities include:

- Promoting adoption and use of Direct secure messaging, including providing guidance and information, conducting and facilitating provider outreach and education, providing presentations, facilitating and connecting user groups, etc.
- Offering CareAccord® (see Section A.7 for more detail) as an option for providers and care team members with no EHR or HISP,
- Facilitating interoperability and interstate exchange through participation in Direct Trust and the National Association for Trusted Exchange (NATE) (see Section A.13 for more detail),
- Expanding CareAccord® services to include functions that enable better integration into providers' workflow, such as:
 - HISP services integrated into EHRs for Medicaid providers ("HISP integration"), which will enable providers to meet the transitions of care measures for Meaningful Use Stage 2;
 - Fillable forms or data entry templates to support common use cases (e.g., transition of care records from long term care facilities). These templates or forms can facilitate the ability of providers receiving the information to ingest the data into the patient record in the provider's EHR;

- Translation for computer-generated attachments to make them human-readable.
- Facilitating provider Direct secure email address look-up through state-level repository services.

Statewide clinical quality metrics registry (CQMR).

Oregon anticipates that the Medicaid EHR Incentive Program will use the CQMR to collect data and the Medicaid enterprise will use the CQMR for multiple purposes. When OHA requests CMS funding for the technology and implementation of the CQMR, an appropriate cost allocation plan will be provided if needed.

OHA is planning to develop the ability to aggregate key clinical quality data for the Medicaid program, develop benchmarks and other quality improvement reporting, and calculate clinical quality metrics for paying quality incentives to CCOs and Medicaid EHR Incentive Payments to providers. Particular focus is on the three clinical CCO incentive metrics that are also EHR Incentive Payment metrics: diabetes poor A1c control, hypertension, and depression screening (see Benchmarks in Section E.3). CCOs can leverage State infrastructure to meet reporting requirements to OHA and receive collected clinical data for their members for analytics/quality improvement.

Technical assistance to Medicaid providers.

The planned Phase 1.5 technical assistance/outreach services are for Medicaid EHR Incentive Program eligible professional types and eligible hospitals. No cost allocation will be required.

Technical assistance to Medicaid providers will help eligible professional (EP) types and eligible hospitals (EHs) meet Meaningful Use requirements, use the information in a meaningful way, and ensure the quality of the clinical metrics data captured by providers in their EHRs are complete and credible. This assistance will be provided to Medicaid EP types and EHs only.

- OHA has engaged in discussions with Oregon’s health systems, CCOs, providers and other stakeholders on what is needed to enhance the likelihood for Medicaid EPs to seek and receive Meaningful Use Stage 2 incentive payments, and more importantly, integrate the concepts into their daily operation. Oregon has undertaken a significant stakeholder engagement process, during which stakeholders identified appropriate technical assistance as a key priority.
- OHA plans to contract for expanded technical assistance/outreach services, similar to REC services, for Medicaid eligible professional types and eligible hospitals. Services are planned to begin in the summer of 2014 and continue into 2017. The REC is not funded to provide technical assistance/outreach beyond primary care providers or for Meaningful Use Stage 2. When providing expanded technical assistance/outreach services, information will be requested from Oregon’s REC to ensure that the services provided are not duplicative of ONC-funded technical assistance.²⁷ The technical

²⁷ A significant portion of Oregon’s Medicaid EPs were not eligible for ONC-funded assistance. O-HITEC calculates that there are a total of 9,385 health care clinicians (MDs, physician assistances, and nurse practitioners) in

assistance/outreach services will be targeted based on a landscape/needs assessment, as described in Section A.1.

10. EXPLAIN THE SMA'S RELATIONSHIP TO THE STATE HIT COORDINATOR AND HOW THE ACTIVITIES PLANNED UNDER THE ONC-FUNDED HIE COOPERATIVE AGREEMENT AND THE REGIONAL EXTENSION CENTERS (AND LOCAL EXTENSION CENTERS, IF APPLICABLE) WOULD HELP SUPPORT THE ADMINISTRATION OF THE EHR INCENTIVE PROGRAM.

Office of Health Information Technology

HIT and HIE efforts are closely coordinated within OHA, the State's single Medicaid agency. For internal coordination, OHA has created an HIT Policy and Program Steering Committee, in which agency leaders address alignment of HIT efforts across program areas, including HIE, the EHR incentive program, analytics, accountability, behavioral health, and public health.

The State Coordinator for HIT works for OHA, and is co-located in the Office of Health Information Technology (OHIT) with staff providing policy analysis for Oregon's Medicaid EHR Incentive Program, drafting the SMHP and related I-APDUs and O-APDUs, and operating the State's CareAccord® HIE program.

CareAccord® was developed under an ONC-funded HIE cooperative agreement, and it currently provides a Direct secure messaging option for Medicaid providers to meet the transitions of care measures for Meaningful Use stage 2. In addition, incentive program staff is expected to start using CareAccord® in January 2014. As described in Section A.8, CareAccord® is in use for communications for Medicaid prior authorizations and appeals, and CMS has approved MMIS funding for CareAccord® operations.

OHIT staff also work closely with the Health Information Technology Oversight Council (HITOC). HITOC supports the administration of the EHR incentive program in several ways, including:

- Communications with providers and stakeholders external to the State government, and
- Key stakeholder input on program development and activities by HITOC members.

Oregon's Regional Extension Center (REC): O-HITEC

The REC, O-HITEC, a division of OCHIN, is a non-profit entity, separate from the State. O-HITEC has helped support the administration of the EHR Incentive Program by helping Oregon Medicaid and Medicare primary care providers to adopt, implement and upgrade to certify EHRs and to reach Meaningful Use Stage 1. OHA staff meets with the REC staff on an ongoing basis regarding priorities and implementation activities. O-HITEC assists Oregon clinicians to select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. O-HITEC offers services that include EHR vendor selection and installation assistance, Meaningful Use evaluation and certification, web-based training,

Oregon, of whom 3,462 are primary care providers. Looking at the numbers a different way, Oregon has a total of 15,017 actively licensed physicians, nurse practitioners, and dentists. Oregon Health Professions: Occupational and County Profiles, February 2013, <http://www.oregonhwi.org/resources/documents/2012ProfilesReportFINAL1.pdf>.

seminars, coordinated participation in learning communities, benchmarking and data warehousing services, HIPAA evaluation and certification. It also offers services to make EHR adoption more affordable including group purchasing, discounted third party solutions, and insurance plans.

OHIT works in close conjunction with O-HITEC to ensure consistency and coordination in efforts related to facilitating EHR adoption and Meaningful Use. The geographic and programmatic diversity of O-HITEC means it can provide support for the administration of the Medicaid EHR Incentive Program in a variety of ways:

- Technical assistance to small providers and critical access hospitals,
- Partnering in communication and outreach,
- Sharing subject matter expertise,
- Coordinating requests for information to clarify federal regulations,
- Coordinating to ensure Oregon-specific requirements related to incentives are appropriately conveyed by O-HITEC to the providers and CAHs they are supporting,

- Alerting each other to risks, issues, concerns, and
- Coordinating with State public health staff related to practicalities of achieving Meaningful Use related to the three public health criteria.

O-HITEC's ONC funding originally was scheduled to expire in February 2014. O-HITEC has applied for a no-cost extension to continue to provide services through February 2015, but no new funding is associated with the extension. Assuming that O-HITEC's application is approved, it is anticipated that the funding will be used for helping the remaining REC-enrolled providers to reach REC milestone 3 by demonstrating Meaningful Use Stage 1. O-HITEC's grant progress is reflected in the table below:

O- HITEC: Grant Progress Report: 8/22/2013

	Number	Percentage	National Average
REC Membership Summary:			
Total Enrolled	2674		
Total Completed MU1	1503	61%	67%
REC Financial Summary:			
Total Grant Award	\$14,597,817		
Grant revenue Drawn Down To Date	\$13,057,451		
Grant Revenue Remaining	\$1,540,366		

11. WHAT OTHER ACTIVITIES DOES THE SMA CURRENTLY HAVE UNDERWAY THAT WILL LIKELY INFLUENCE THE DIRECTION OF THE EHR INCENTIVE PROGRAM OVER THE NEXT FIVE YEARS?

CareAccord®, SIM Grant, EDIE

See responses to Section A.7 (CareAccord®); Section A.15 (SIM); Section A.6 (EDIE).

Related State efforts

OHIT coordinates with:

- Office for Oregon Health Policy and Research (OHPR) and its efforts around an All Payer All Claims database (APAC),
- The Oregon Public Health Division (OPHD) and its efforts toward interoperability of immunization and public health surveillance activities,
- Addictions and Mental Health Division’s efforts to develop a community behavioral health EHR,
- Oregon workforce efforts,
- DHS/OHA efforts to transform State IT systems,
- other HIT grants including Oregon’s Medicaid Transformation Grant and Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration grant, and Oregon’s MMIS certification, Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A), and the DHS/OHA 2009-2015 technology plan.

All Payer All Claims Database

In 2009, the Oregon Legislature established a health care data reporting program. The Office for Oregon Health Policy and Research is creating a comprehensive data collection program of all claims paid by all health care payers, including commercial insurers, third party administrators, pharmacy benefit managers, Medicare, and Medicaid. The program will provide information for policy and analytical purposes covering services across health care settings. Oregon’s All Payer All Claims Database (APAC) contains utilization data, outcome information and payment information on a statewide basis.

Behavioral Health Providers

OHA's Office of Health IT (OHIT) coordinates closely with OHA's Addictions and Mental Health (AMH) Division. In 2012, AMH launched a project called COMPASS that includes a comprehensive behavioral health electronic data system to improve care, control cost and share information.

This new data system will allow AMH to meet business needs and requirements and will provide data that more readily supports the ability to track:

- Performance outcomes associated with services;
- Who accesses services, what services are provided, where and when; and
- Improvement in the health of Oregonians through better quality and availability of healthcare, and cost effectiveness of services.

What are the different components of COMPASS?

- AMH's OWITS Behavioral Electronic Health Records (EHR): OWITS is available to all publicly funded behavioral health providers or required reporters (ex: DUII, methadone or detox providers). One advantage to providers of using the OWITS EHR is that agencies will no longer need to submit the required client data to AMH. AMH will automatically pull all required data from the system and ensure that all data requirements are included within the system. Timeline: Implemented July 2011.
- Measures and Outcomes Tracking System (MOTS): This is the electronic exchange of data with AMH. There will be three methods for data submission: (1) OWITS EHR; (2) Electronic Data Interchange/Transfer from existing EHRs; and (3) MOTS Client Data Entry web portal. Timeline: Begin accepting data December 5, 2013.
- AMH Contracts and Payments System: This new system and processes will streamline contracts and billing by moving to a web-based electronic process. AMH will better track funding streams and reduce the number of contract amendments. Timeline: Implemented July 2013.

Note: OWITS provides a web-based EHR for mental health and addiction services community-based programs that allows for the exchange of patient data between community providers. OWITS includes an open-source, 2011-certified EHR. The OWITS application also provides a secure, central location for meeting reporting requirements. It launched in July 2011 and currently is available to publicly funded behavioral health providers. Continuing support for OWITS is funded through the end of Oregon's biennial budget cycle in June 2015. (The funding for OWITS is not HITECH funding.)

Current Behavioral Health

Just over 90 percent of Oregon's Medicaid population is now enrolled in 16 community-based CCOs, which cover all regions of the state. The CCOs are responsible for physical, behavioral, and oral health care for CCO members. In 2013, Oregon was one of six states to be awarded a

SIM grant from the CMS Centers for Medicare and Medicaid Innovation (CMMI) for up to \$45 million for three and a half years. The SIM grant funds a number of efforts, including a new Transformation Center within OHA, which evaluates methods of integration and coordination between primary, specialty, behavioral health and oral health.

CareAccord® participants include ambulatory providers, long term care, behavioral health, a CCO, and OHA Medicaid and public health programs. As of December 30, 2013, CareAccord® has 936 registered accounts for 116 Organizations. The HIT Task Force recommended “whole person care” that requires HIT for integration of behavioral health, oral health, long term care, jails and other social services, especially for “closed loop” coordination of care referrals.

Workforce Development

Oregon is leading cutting-edge efforts to train the HIT workforce through both OHSU’s Department of Medical Informatics and Clinical Epidemiology and Oregon’s community colleges, including Portland Community College (PCC). OHSU received two federal stimulus grants from the ONC; one to train certificate and master’s level students in informatics and the second names OHSU as one of five curriculum development centers around the country. OHSU was also selected to be the National Training and Dissemination Center for the latter project. PCC was the lead Oregon community college receiving money through the national Community College Consortia Program to partner with four other community colleges in Oregon to train and place 300 HIT workers in jobs. Each college created non-degree training programs that can be completed in six months or less.

Health Insurance Marketplace and commercial plans

Oregon received one of seven awards from the Innovative Exchange Information Technology Systems Cooperative Agreement program with the U.S. Department of Health and Human Services. The \$48 million Cooperative Agreement funded Oregon’s efforts to build an information technology infrastructure to support a State health insurance exchange.

Oregon is working to expand the coordinated care model beyond Medicaid to public employees covered through the Public Employees Benefit Board (PEBB), Medicare for individuals who are dually eligible for Medicaid and Medicare, and commercial payers purchasing plans in Cover Oregon, the State health insurance exchange.

12. HAVE THERE BEEN ANY RECENT CHANGES (OF A SIGNIFICANT DEGREE) TO STATE LAWS OR REGULATIONS THAT MIGHT AFFECT THE IMPLEMENTATION OF THE EHR INCENTIVE PROGRAM? PLEASE DESCRIBE.

Oregon updates its regulations (Oregon Administrative Rules or OARs) relating to the EHR Incentive Program as needed to keep the program in compliance with CMS’s regulations. The current version of the OARs can be found at

http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_165.html.

Initial legal and regulatory changes

When the Oregon Legislature passed HB 2009, it instituted a variety of reforms to Oregon's health system to contain costs and improve quality, including planning and implementing health IT. In particular, HB 2009 established HITOC to carry out and oversee HIT activities in Oregon.

Oregon's health reform law also mandated the creation of a comprehensive data collection program of all claims paid by all health care payers. The All Payer All Claims Database (APAC) will collect claims information from all payers for policy and analytical purposes covering services across health care settings.

Anticipated legal and regulatory changes

Statewide HIT/HIE infrastructure is essential for supporting health care transformation efforts, and requires significant financial investment and ongoing financial sustainability. Current CareAccord® services were developed using federal funding from the ONC HIE Cooperative Agreement (through February 2014), and operations now are supported by MMIS funding with state match (see Appendix G for the CMS approval letter for MMIS funding; also see Section C.30). Currently, there are no private funds used or fees charged for CareAccord®. The HIT Task Force (described in Section A.5) has recommended OHA should seek legislative authority to set and charge fees for HIE services.

The HIT Task Force also recommended the designation of an HIT designated entity that would implement policies and requirements developed by the State. The entity would:

- Become the central contracting point for data use and business associate agreements with regional and local HIOs and data providers;
- Contract with technology vendors to implement and operate statewide HIE/HIT enabling infrastructure;
- Coordinate with and support local efforts via HIE programs.

The Task Force noted that although its recommendations set direction for moving state-operated services into an external entity, more definition is needed. Depending on the direction developed, legislative changes may be needed to support the development of the designated entity.

13. ARE THERE ANY HIT/E ACTIVITIES THAT CROSS STATE BORDERS? IS THERE SIGNIFICANT CROSSING OF STATE LINES FOR ACCESSING HEALTH CARE SERVICES BY MEDICAID BENEFICIARIES? PLEASE DESCRIBE.

Oregon's HIE Strategic Plan recognizes that patients frequently cross state borders seeking medical care, particularly at Oregon's borders with Washington and Idaho. Oregon collaborates with bordering states to address the HIE concerns that arise as a result of interstate activities. Working with the state coordinators for HIT in bordering states, Oregon is weighing policy challenges to seamless interstate HIE, and consulting with other state collaboratives and the ONC for emerging policies and best practices.

National Association for Trusted Exchange (NATE)

Oregon is a member of the NATE (formerly the Western States Consortium, WSC). NATE focuses on developing the necessary policies and procedures to create an appropriate level of trust between different Health Information Service Providers (HISPs) operating in different states, to create a multi-state, scalable solution to seamless Direct exchange among unaffiliated providers and organizations.

A foundation piece to the NATE effort was a proof of concept pilot demonstration that established a governance model to support secure exchange between health care providers in Oregon and California. The technical goals for the project focused on establishing a trust community; exchanging digital certificates between HISPs through a trust anchor store, and exploring ways to discover provider attributes within the provider directories of different HISPs. NATE developed policies to address questions about business agreements between HISPs, security and privacy protocols, acceptable interstate uses of Direct exchange, and identity validation through registration and certificate authorities. The consortium established a governance structure based on a Memorandum of Understanding (MOU) that extended the trust environment to enable interstate Direct exchange. In 2012, NATE completed two pilot demonstrations in which Direct messages were successfully exchanged between California and Oregon, that is, across state lines and between different HISPs while using scalable distributed provider directory services.

Current NATE trust community

Currently CareAccord® users can exchange Direct secure messages with other NATE participants whose HISP's digital certificates have been added to the trust anchor store, and identify those providers through the NATE federated directory without having to know a provider's Direct account address. The HISPs currently included in the NATE trust community are California (North Coast Health Information Network, Santa Cruz Health Information Exchange, San Diego Health Connect), Utah (Utah Health Information Network) and Alaska (Alaska eHealth Network).

Personal Health Records pilots

Along with Alaska and California, CareAccord® is currently participating in an ONC/NATE Personal Health Record (PHR) pilot, which ends in early 2014. The aim of this pilot is to test the enablement of the wider use of PHRs as a vehicle for patients to send and receive data bi-directionally with their providers via Direct. The PHR pilot use cases were designed to inform privacy and security policies and operational policies for patients' access to exchange information, and future technical efforts. The results are to inform a roadmap for proceeding to a scalable deployment of a trusted mechanism which would enable the use of PHRs for exchange across multiple states. CareAccord® is facilitating online exchange of clinical health information between the parents of chronically ill children and their pediatric patient-centered primary care home. Using the patients' free HealthVault PHR account, parents can receive and send messages to providers without using disparate messaging systems.

Direct Trust

In October 2013, CareAccord® became the first state Health Information Exchange in the nation to receive full Direct Trusted Agent Accreditation (DTAAP). DTAAP recognizes excellence in health data transactions; ensures compliance with industry-established standards, HIPAA regulations and the Direct Project. Direct Trust accreditation is a gateway to allow Oregon providers to expand the number of providers they can share with in a trusted and secure community that is not restricted by organizational or geographical boundaries. There are currently eight members in Direct Trust's trust community, and about a dozen working toward accreditation, several of whom will soon provide Direct secure messaging HISP services to Oregon hospitals and health systems. (See <http://www.directtrust.org/accreditation-status/>.)

This accreditation allows CareAccord® subscribers access to exchanging information with unaffiliated providers and organizations throughout the nation, who are not using CareAccord®, but are members of another Direct Trust accredited HISP. The benefit becomes that Medicaid providers using CareAccord® now have a means to meet the transitions of care measures for Stage 2 Meaningful Use by exchanging across different organizations and different EHR vendors.

14. WHAT IS THE CURRENT INTEROPERABILITY STATUS OF THE STATE IMMUNIZATION REGISTRY AND PUBLIC HEALTH SURVEILLANCE REPORTING DATABASE(S)?

Public health initiatives

Public health initiatives that promote and enhance Medicaid provider use of EHRs by fostering information exchange between providers/hospitals and OHA's Oregon Public Health Division (OPHD) data systems include:

- Maintain public health Meaningful Use web presence at <https://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/MeaningfulUse/Pages/index.aspx>;
- Collaborate with providers and evaluate other State and regional methodologies to determine the best means for providing technical assistance to providers;
- Continue to provide technical assistance documentation for providers (including which data elements are required by Meaningful Use and must be included to meet any Oregon program specifications, methods for secure transmission of data, verification of receipt of data, methods for testing and validation, and contact information for questions); and
- Provide guidance and technical assistance, which is maintained, updated and available on the State web page.

Public health databases and interoperability

Public health programs collect and analyze data on health behaviors, diseases and injuries; disseminate findings; and design and promote evidence-based programs and policies to improve the health and safety of all Oregonians. OPHD operates many programs, including programs that

- work with local health departments, other states and the Centers for Disease Control and Prevention (CDC) to prevent and control communicable diseases and outbreaks of acute diseases in Oregon;
- work with hospitals and laboratories to collect population data to track cancer incidence;
- administer programs aimed at improving the overall health of Oregon's women, infants, and children through preventive health programs and services; and
- provide leadership to prevent and mitigate vaccine preventable disease for all Oregonians by reaching and maintaining high lifetime immunization coverage rates.

The ongoing collaboration and integration of systems used by each of these programs are essential to understanding and improving the health of Oregonians. See Section C.12 for descriptions of Meaningful Use reporting to these and other public health systems.

Oregon's ALERT Immunization Information System (IIS)

ALERT IIS is a statewide system that contains records for 4.5 million individuals, including current and past Oregonians of all ages along with some residents of Washington. ALERT IIS is used by more than 7,500 public and private health care providers and school staff from 1,500 different sites to link data and create accurate and up-to-date records and to provide accurate information on immunizations due and past due. ALERT IIS receives approximately 80% of immunization records via electronic submission.

Public health services participation in HIE

OPHD will also participate in Oregon's HIE. In 2013, programs in OPHD began registration for CareAccord® accounts. Further work is needed to support development of more sophisticated HIE services, such as developing one or more interfaces to the State HIE, facilitating bi-directional data sharing, enabling access to public health services for providers and contributing to the development of a shared services and data architecture.

Electronic laboratory reporting and Oregon Public Health Epidemiology User System (Orpheus)

Orpheus currently houses all communicable disease data, including sexually transmitted infections, tuberculosis, elevated blood lead levels, and HIV/AIDS case data dating back to 1983. Electronic laboratory reports (ELR) from laboratories around the region are routed through a central repository within OPHD. HL7 data received from laboratories are routed directly into the State's communicable disease reporting database (Orpheus). ELRs are routed to Orpheus via HL7 and processed and investigated by local public health, and data for nationally notifiable diseases are transmitted to CDC using nationally recognized standards (i.e., NETSS and HL7). Providers do not interact with Orpheus directly, but they do report cases of communicable disease directly to local public health for investigation and follow-up.

Syndromic surveillance

The Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) collects and analyzes health data for the purposes of detecting and characterizing trends of illness or injury in a timely manner. Stakeholders, including entities outside of public

health, benefit from greater situational awareness of real-time disease activity across communities. Critical to the long-term success of this surveillance is the quick, efficient and automated transmission of critical data from clinical systems to the appropriate public health agencies.

Oregon ESSENCE launched in the spring of 2012. It provides real-time data for public health and hospitals to monitor what is happening in emergency departments across the state before, during and after a public health emergency. Participating facilities are encouraged to leverage EHRs to automate reporting of health records.

Interoperability between public health systems

The ELR and Orpheus systems are now integrated. Subject to security parameters, users of Orpheus have access to ELR data (relevant to their jurisdiction and access privileges).

Efforts are underway to routinely exchange information between Orpheus and ALERT IIS, Orpheus and ESSENCE, and ALERT IIS and the Early Hearing Detection and Intervention (EHDI) Program. For ALERT IIS, initial efforts to exchange information with Orpheus will use the same system of real-time web-service query available to providers. Conversations are underway about the feasibility of exchanging data such as patient lists by condition and case reporting between public health systems and EHRs.

15. IF THE STATE WAS AWARDED AN HIT-RELATED GRANT, SUCH AS A TRANSFORMATION GRANT OR A CHIPRA HIT GRANT, PLEASE INCLUDE A BRIEF DESCRIPTION.

CHIPRA Consortium

The Tri-state Children's Health Improvement Consortium (T-CHIC) is an alliance between the Medicaid/CHIP programs of Alaska, Oregon and West Virginia formed with the goal of markedly improving children's health care quality. The Oregon-led consortium is working on a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration to demonstrate the unique and combined impact of patient-centered care delivery models and health information technology (HIT) on the quality of children's healthcare, as measured by a variety of indicators.²⁸

The project aims to determine the level of feasibility for providers to report on CMS's recommended set of pediatric core measures through data captured in EHRs, as well as to determine the impact that these systems have on children's health outcomes. Alignment of T-CHIC activities with both national and state HIT development will be ensured through coordination of efforts with HITOC and the State Medicaid Director.

Medicaid Transformation Grant

Oregon DHS received from a Medicaid Transformation Grant (MTG) for \$5.5 million in October 2007 to implement a Health Record Bank of Oregon (HRBO). The initial term of the grant award

²⁸ Oregon HIE Strategic Plan, p. 68.

was 18 months from October 2007 through March 2009. CMS extended the grant through March 2011.

The DHS Executive Committee for this grant approved a revised plan at its meeting March 10, 2010 meeting. The scope of the project was amended and the balance of funds re-allocated to initiatives consistent with the original intent of the HRBO, achievable within the time available.

The revised project included five mutually supportive component areas:

- *Health Profiles for Children in Foster Care.* The original HRBO project focused on several target populations, the highest priority of which was children in the care and custody of the foster care program administered by DHS. DHS decided to enhance the capacity of its new OR-Kids Child Welfare information system, by adding functionality to generate a personal health report or "Health Profile" for children in its care. The new Health Profile function aggregates and filters information from the MMIS claims database and additional data from the Oregon immunization registry to generate an on demand Health Profile for each foster child. Grant funds enabled OR-Kids to develop and validate the utility of these Health Profiles in the field. Health Profiles are tailored to five audiences: case workers, parents and guardians, foster care providers, health care providers, and individual clients upon reaching 18 or emancipation.
- *Immunization Information System (IIS) enhancements.* Immunization data is highly valued by the health care provider community. To make IIS data more available to providers and others who need it, and to enable providers with EHR systems to easily provide updated immunization information to the IIS, DHS supported the Public Health Division by amending the existing contract with Hewlett-Packard (HP), the IIS contracted vendor to develop a bidirectional web services interface. The interface allows real-time immunization data export to OR-Kids in support of the Health Profile, and as providers activate EHR information exchange capabilities, it enables data exchange directly with those providers' EHRs.
- *Immunization Information System (IIS) interfaces for health providers' EMRs.* Immunization information for health care providers serving higher numbers of foster care children, beyond the access provided by the Health Profile (above) were further facilitated by strategic investments in EHR interfaces to IIS. DHS/OHA solicited small proposals from providers operating EHRs to support the development, deployment and operation of EHR to IIS interfaces for the products of leading Oregon EMR vendors, serving Medicaid recipients. Nine projects were completed for an average of \$132,323 per recipient.
- *Information policy and business analysis.* The HRBO project uncovered several foundational business and information technology policy challenges that needed to be addressed for current Medicaid operations and planning for future HIE. These challenges include approaches to managing: (a) foster care child data, (b) professional and client identity verification, (c) presentation of family and other relationships and (d)

adolescent data. The policy and business analyses were designed to capitalize on the findings, and generate new knowledge for DHS and CMS. The analyses required involvement of State personnel including the Oregon Department of Justice and external consulting and university research groups with whom the State has standing contractual relationships.

- *School-based health center project.* Because of efficiencies in execution of other projects, and with CMS approval, DHS added a fifth component of the Medicaid Transformation Grant focused on school-based health centers (SBHCs). DHS executed contracts for purchasing at least three certified EHR systems with associated data reporting software, for training provider staff in their use and for support and maintenance of the systems for 2 years. Contract recipients provided data services and deployed a customized process for SBHCs to report specific data elements to the State. SBHCs that participated in the pilot were able to bill Medicaid efficiently for their services to eligible persons and report data to the State to maintain certification.. Due to these efforts, eligible professionals within SBHCs may qualify for Medicaid EHR incentive payments.

For all five of the project components above, DHS strategy emphasized working within existing contracts and work orders to the extent possible, in order to leverage existing relationships and mitigate schedule risks due to time consuming procurement processes. Finally, the components designed to facilitate EHR adoption and Meaningful Use (including electronic submission to the immunization registry) will facilitate Oregon's HIT and HIE planning and development as those efforts go forward.

Health Insurance Marketplace

Oregon has established a Health Insurance Marketplace, as envisioned in federal and state health reform. Oregon is one of seven states or coalitions that received grant funding through the federal Insurance Exchange IT innovator program. Oregon's plans for the innovation grant include:

- A seamless, easy-to-use eligibility determination process to help individuals figure out whether they are eligible for Medicaid or federal premium tax credits;
- Access to health plan cost and quality information that Exchange consumers can use in selecting plans and providers;
- A process for easy enrollment into commercial health insurance plans and Medicaid; and
- Billing and payment functions (including administration of the new federal health insurance tax credits, in partnership with the federal government).

The IT Innovator grant funding supports the State's effort to modernize Medicaid eligibility and enrollment processes. This gives Oregon a singular opportunity to develop seamless and efficient enrollment systems for Oregonians regardless of whether they qualify for Medicaid or will purchase commercial insurance. Together, the health insurance exchange and eligibility and enrollment modernization projects will form a framework for achieving several of the IT goals in

the DHS/OHA IT Technology plan and provide the basis for broader service-oriented architecture that will benefit other State systems and Medicaid-related programs.

Centers for Medicare and Medicaid Innovation (CMMI) State Innovations Model (SIM)

CMMI awarded a SIM grant to Oregon for up to \$45 million for three and a half years. The grant is for testing innovative approaches to improving health and lowering costs across the health care system, including Medicaid, Medicare, and the private sector. The grant will support the state's ongoing health system transformation and provide opportunities for Oregon to share what it learns with other states. The SIM grant funds a number of efforts, including a new Transformation Center within OHA, which evaluates methods of integration and coordination between primary, specialty, behavioral health and oral health.

Oregon's SIM grant focuses on innovation in three areas: innovation and rapid learning, delivery models, and payment models. Work includes:

- Integrating and coordinating care among primary, specialty, mental and behavioral health, and oral health providers;
- Engaging patients and consumers in their own care for better outcomes;
- Engaging providers in health system transformation;
- Improving community health through local partnerships that support promotion and prevention activities;
- Implementing more effective health care payment models that incentivize better health;
- Encouraging consensus-building to support primary care payment reform, which now includes more than 25 payers, provider organizations and other key partners;
- Implementing and sharing across Oregon's health care sector those innovations and best practices that reduce health disparities;
- Supporting health information technology and exchange – building on other HIT funding in Oregon with SIM investments, technical assistance to ensure innovation and successful implementation;
- Funding pilot projects in local health departments to promote integration of public health and health care, innovation, and healthy communities;
- Improving quality and health outcomes for those eligible for both Medicaid and Medicare;
- Integrating long-term care – reviewing options for shared accountability between long-term care and CCOs.

In Oregon, SIM activities support transformation beyond Medicaid:

- Learning collaboratives;
- Council of clinical innovators;
- Bringing payers and providers together for alternative payments efforts initially in primary care and then spreading to broader payment approaches;
- Bringing together the hospitals across the state to coordinate care (SIM funding provides an opportunity to set up an Emergency Department Information Exchange

(EDIE), a solution to exchange information among emergency departments to identify frequent users. Working with the primary care providers in their communities, the hospitals can create care plans to help those frequent emergency department utilizers to determine if there is a more appropriate care setting);

- Technical assistance in the areas of promoting health
- Technical assistance in the areas of promoting health equity, consumer engagement, and provider engagement (this includes providing operational support for the three additional regional health equity coalitions, supporting three new cohorts of participants in the Developing Equity Leadership through Training and Action program, or DELTA, and certifying 150 new health care interpreters;
- Working with the Patient-Centered Primary Care Institute, including trainings, webinars and provider-level learning collaboratives for all primary care providers in the state.
- Improving the state’s analytic infrastructure and tools to allow for more integrated, linked and accessible data in a secure environment (this will support data analytics needs at multiple levels and improve transparency of health and health care data); Implementation and evaluation support for the housing with services program – a new model that would incorporate housing and social services to improve health outcomes for older adults and people with disabilities;
- Coordination with early learning councils and hubs, specifically concerning support of kindergarten readiness.

The SIM grant is an opportunity for Oregon to strengthen and support the coordinated care model and to spread key elements of the model, such as Patient-Centered Primary Care Homes (PCPCH, Oregon’s medical home model), available to others such as Public Employees’ Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), and Medicare beneficiaries. Oregon’s SIM grant also supports some of OHA’s HIT/HIE efforts, including funding part of Oregon’s EDIE project (see Section A.6), supporting consultant and other costs, and ensuring that OHA’s HIT/HIE efforts that spread beyond the Medicaid program are appropriately supported.

Portions of the SIM grant are being used for HIT/HIE needs to test new approaches and spread the coordinated care model. As a general principle for HIT/HIE work, OHA considers I-APD-U funding first when the primary focus is Medicaid uses and providers. OHA looks to SIM funding first when the primary focus relates to spreading beyond Medicaid. OHA may also use SIM funding to test new HIT/HIE approaches before committing to strategies or approaches which, if adopted, may tie to IAPD funding. OHA will continue to work closely with CMMI and CMS to ensure that all costs are appropriately attributed and that duplicative efforts are not funded or carried out.

Information about the work being done under Oregon’s SIM grant is available here:

<http://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx>. Oregon’s SIM Operational Plan is posted here:

http://www.oregon.gov/oha/OHPR/SIM/docs/Oregon%20SIM%20OpPlan%2010%2025%2013_Final.pdf.

SECTION B: THE STATE'S "TO-BE" LANDSCAPE

1. **LOOKING FORWARD TO THE NEXT FIVE YEARS, WHAT SPECIFIC HIT/E GOALS AND OBJECTIVES DOES THE SMA EXPECT TO ACHIEVE? BE AS SPECIFIC AS POSSIBLE; E.G., THE PERCENTAGE OF ELIGIBLE PROVIDERS ADOPTING AND MEANINGFULLY USING CERTIFIED EHR TECHNOLOGY, THE EXTENT OF ACCESS TO HIE, ETC.**

Vision of an "HIT-Optimized" Health Care System

The vision for Oregon's transformed health system includes statewide HIT/HIE efforts that ensure all Oregonians have access to "HIT-optimized" health care. "HIT-optimized" health care is more than the replacement of paper with electronic or mobile technology. It includes changes in workflow to assure providers fully benefit from timely access to clinical and other patient information that will allow them to provide individual/family-centric care. In a "HIT-optimized" health care system:

- Individuals have meaningful and timely access to their personal health information and are encouraged and empowered to engage in achieving positive health outcomes.
- Providers coordinate and deliver "whole person" care informed by meaningful, reliable, actionable patient information.
- Systems (health systems, health plans, CCOs) are supported in efficiently and effectively using aggregated data for comparability for quality improvement, population management and to incent value and health outcomes.
- Policymakers leverage and utilize aggregated data to provide transparency into the health and quality of care in the state, and to inform policy development.
- All use HIT to realize the Triple-Aim of better health outcomes, better quality care, and lower costs.

To create an "HIT-optimized" individual-centric health ecosystem, the State has a role, as do CCOs, health plans, health systems, local health information exchange efforts, providers and individuals. The central relationship between providers and their patients is often supported by technology locally: at the practice level, health system level, health plan and/or CCO level. To support what's happening locally, State efforts can provide the right level of statewide technology, policies and operational guidance to ensure privacy, security and accountability, while also ensuring appropriate and sustainable financing and governance.

Imperatives

According to the CMS State Medicaid Director's Letter of August 2010, HIT efforts funded by CMS must:

- Directly facilitate the adoption and Meaningful Use of EHR;
- Be consistent with the HIE vision and specifically secure messaging, e-prescribing, and the electronic reporting of laboratory data;
- Not be duplicative of other efforts;
- Be integrated into the Medicaid business enterprise;
- Not be qualified for MMIS funds, MMIS funds be used first when applicable;

- Have a well-defined, achievable scope with Meaningful Use of EHRs as the goal;
- Be able to sustain operations after the goal is met and HITECH funding is no longer available;
- Adhere to Medicaid Information Technology Architecture (MITA) principles;
- Follow the fair share principle of cost allocation with other beneficiaries; and
- Work with CMS to determine appropriate cost allocation.

Goals for State HIT/HIE efforts

In particular, the HIT Task Force (described in Section A.5) set forth recommendations for State efforts that achieve the following goals. Note – the goals for Medicaid-specific efforts are focused on Medicaid providers within the context of the larger State efforts:

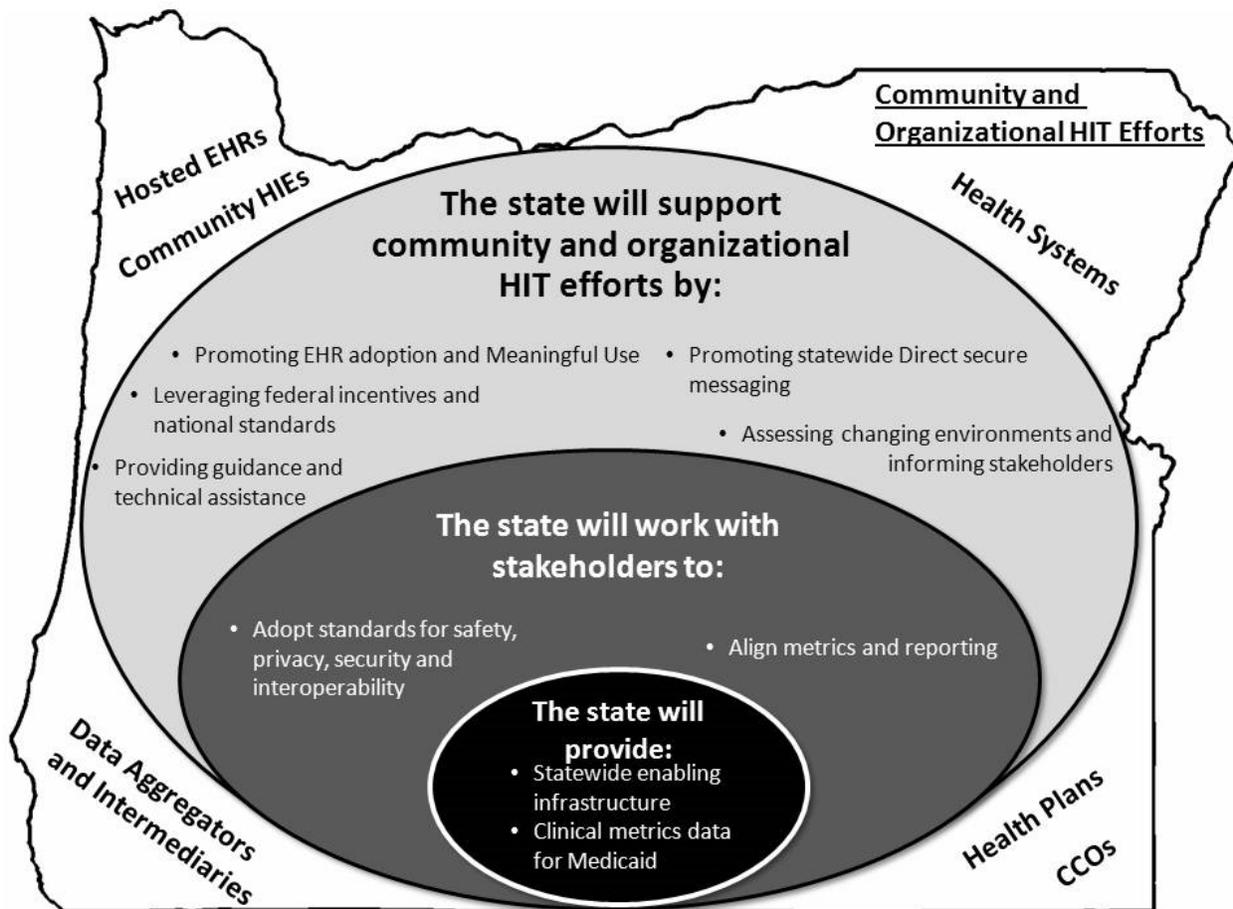
- Ensure all providers can access meaningful, reliable, actionable patient information shared across organizations and differing technologies through community, organizational and/or statewide health information exchange. To do so, State efforts will:
 - Support and facilitate provider adoption and Meaningful Use of certified EHRs, and support the goal that all providers have a means to use key patient information, including behavioral health, dental and long term care.
 - Support the protection, privacy and security of shared patient information.
- Support CCOs, health systems, health plans, and providers in using aggregated data for quality improvement, population management, and to incent value and health outcomes.
- Facilitate individual and family or caregiver engagement through access to and interaction with their health information.

Approaches to State HIT/HIE efforts

To support these goals, specific State efforts are described in the figure below (and more fully described in the Business Plan Framework, attached as Appendix A). This includes:

- Promoting EHR adoption and Meaningful Use through a variety of efforts, including communication and outreach efforts, operating Oregon’s Medicaid EHR Incentive program, supporting and using State levers to drive EHR adoption and Meaningful Use (e.g., State contracts, PCPCH standards, etc.).
- Aligning State metric reporting requirements with Meaningful Use requirements to further incentivize EHR adoption, Meaningful Use, and HIE and leverage automated capabilities within EHRs, such as CCDA/QRDA formats for clinical metric reporting required for Medicaid purposes.
- Providing guidance and technical assistance, including REC-like technical assistance services to Medicaid providers.
- Promoting statewide Direct secure messaging as a baseline for health information exchange statewide.
- Assessing changing environments at the national and local levels, anticipating upcoming changes, and informing stakeholders.

- Promoting policies and practices to protect patient information and ensure any statewide services or processes follow HIPAA and other federal and State requirements.
- Supporting interoperability, including the establishment of a State HIT/HIE compatibility program that includes national standards and sets baseline expectations for entities accessing State enabling technology, to ensure interoperability, privacy and security, and facilitate sharing of information.
- Aligning metrics and reporting requirements to reduce provider burden, achieve efficiencies and leverage local and State-level investments.
- Providing State-level technology services (described below and in Section B.2) including near-term services (Phase 1.5) and longer-term services (Phase 2.0) that enable health information exchange and use of aggregated data.



The technology, governance, policy, and finance approaches are summarized below (and more fully described in Appendix A, Business Plan Framework):

Technology

The overall approach to statewide HIT/HIE coverage relies on the following five elements (see Section B.2 for more information):

- Community and organizational HIEs and health systems provide HIT and HIE services to some providers.
- Statewide Direct secure messaging provides a foundation for sharing information across organizations and differing technologies.
- CareAccord® provides common services including Direct secure messaging as baseline HIE capabilities to those without access to community or organizational HIEs. CareAccord® subscribers access statewide enabling infrastructure services through CareAccord®. (Example: Medicaid providers submit prior authorizations and appeals through CareAccord)
- Statewide enabling infrastructure services ties local efforts together where they exist and provides enabling HIE and HIT functions (such as identifying providers or locating patient records) across community and organizational HIEs, health systems, providers, and other entities. Statewide infrastructure will be phased. (See Sections A.9 and B.2 for description of Phase 1.5 and Phase 2.0).
- State aggregation of core clinical data for Medicaid purposes, with a focus on a small set of Meaningful Use clinical quality measures.

Governance, Policy, and Operations

The State will provide oversight, transparency, policy and legal guidance, and accountability for statewide HIT/HIE services, and will contract with an external HIT Designated Entity to operate the statewide services in Phase 2.0.

To ensure interoperability, privacy and security of information exchanged through statewide services and to protect privacy, OHA will establish a new HIT/HIE compatibility program. Any entities seeking to utilize State enabling infrastructure services would need to meet program expectations.

Finance

State efforts should address financial sustainability through development and implementation of a broad-based financing model. OHA will consider seeking fee-setting and collecting authority for HIT/HIE services.

Objectives for State HIT/HIE efforts

Given the above vision, goals, and approaches to statewide HIT/HIE efforts, OHA has established the following objectives:

Objective 1: Increase access to patient information shared across organizations and differing technologies, to achieve statewide interoperable, secure exchange of patient information:

- Objective 1.1: Increase the number of Medicaid eligible providers adopting and meaningfully using certified EHR technology.
- Objective 1.2: Increase providers' ability to coordinate care across practice settings (including information exchange between providers who are eligible for EHR incentives and those providers who are not eligible, such as long term care providers) by increasing

adoption of Direct secure messaging and access to other health information technologies by behavioral health, dental and long term care providers. As there is no charge for CareAccord® Direct secure messaging, it becomes a viable option for those Medicaid providers who are not eligible for EHR incentives to communicate vital information. No HITECH funding is required or being requested to fund long term care and/or behavioral providers.

- Objective 1.3: Increase adoption and use of Direct secure messaging that is interoperable across EHR/HISP vendors.
- Objective 1.4: Increase use of CareAccord® Direct secure messaging services targeted to Medicaid programs, providers, and other members of health care teams, particularly those without access to EHRs and/or HISP services.
- Objective 1.5: Improve sharing of patient information across community and organizational HIT efforts.

Objective 2: Improve use of aggregated clinical data for Medicaid and other State programs, CCOs, health plans, and other health system partners.

- Objective 2.1: Improve availability of core clinical outcomes data from Medicaid providers for policy, analytic, quality improvement, and operational purposes.
- Objective 2.2: Improve ability of Medicaid and other State programs, CCOs, health plans and other health system partners to aggregate data for policy, analytic, quality improvement, and operational purposes.

Objective 3: Improve individual/family access to their meaningful health information

2. WHAT WILL THE SMA'S IT SYSTEM ARCHITECTURE (POTENTIALLY INCLUDING THE MMIS) LOOK LIKE IN FIVE YEARS TO SUPPORT ACHIEVING THE SMA'S LONG TERM GOALS AND OBJECTIVES? INTERNET PORTALS? ENTERPRISE SERVICE BUS? MASTER PATIENT INDEX? RECORD LOCATER SERVICE?

In order to support providers' access to meaningful, reliable, actionable patient information shared across organizations and differing technologies; and to support systems' use of aggregated data, OHA will provide state-level enabling infrastructure that can facilitate both "push" and "query" capabilities. OHA will continue to operate CareAccord® to serve Medicaid operations and to provide an option for any provider to access electronic health information with or without an EHR, through Direct secure messaging.

Phased approach

OHA plans to implement state-level HIT/HIE services in phases:

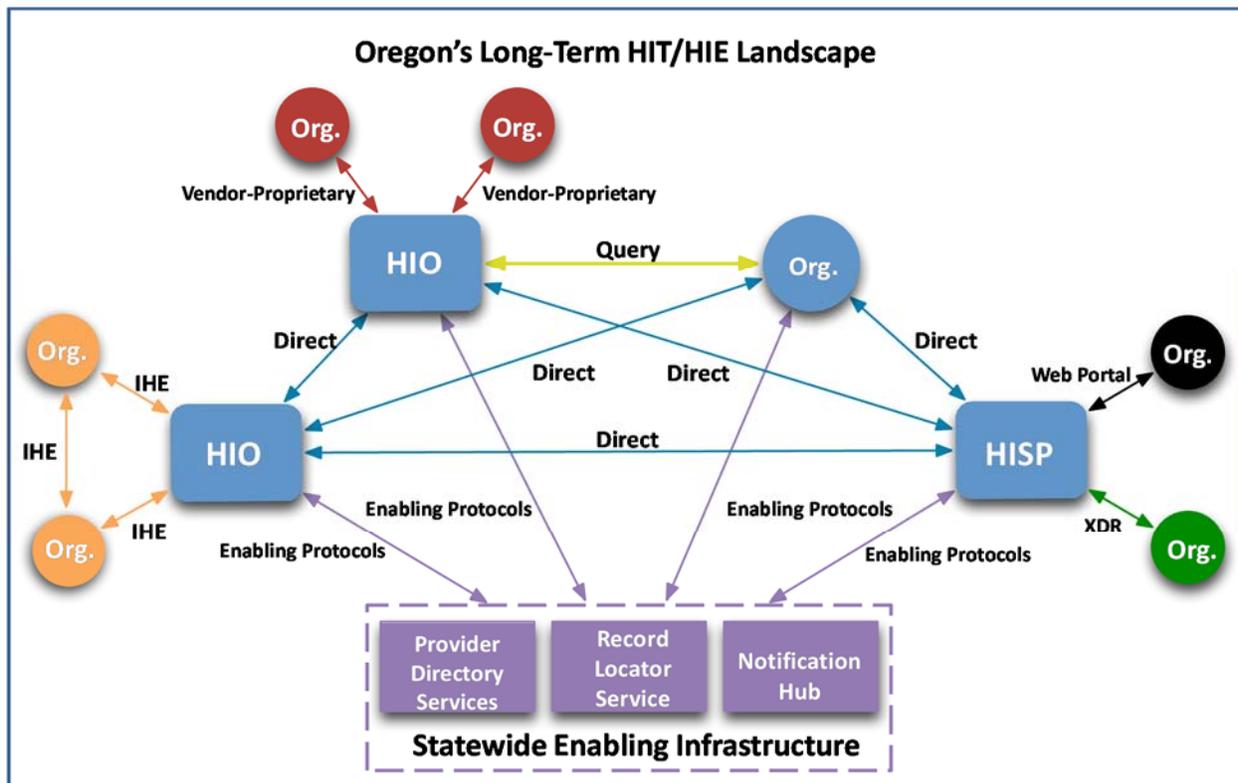
- Phase 1 (current): The current services include CareAccord® Direct secure messaging.
- Phase 1.5 (2014-2015): OHA is planning Phase 1.5 activities for the first part of the five years addressed in this SMHP-U. New foundational services will be implemented (see Section B.9 for Phase 1.5 detail), including
 - Provider information repository services,
 - Expanding Direct secure messaging,

- Statewide hospital notifications,
- Incremental development of a patient/provider affiliation service,
- Clinical quality metrics registry for Meaningful Use metrics from Medicaid providers,
- Technical assistance to Medicaid practices.
- **Phase 2.0 (2015 and beyond):** During the second part of the five years addressed in this SMHP-U, Oregon will expand Phase 1.5 services and develop new services that allow for more robust HIT/HIE capabilities.
 - Expanding provider information, patient/provider affiliation and notification hub functionality
 - Supporting “query” services, in line with national standards, potentially requiring a Record Locator Service

As described below, Oregon has set a strategic direction for Phase 2.0. More detailed plans for Phase 2.0 services will be fleshed out over time, in a way that is responsive to the changing landscape and evolving standards. Updates will be provided in later SMHP-U's and I-APD-U's.

Phase 2.0: Long-Term HIT/HIE Landscape

The diagram attempts to illustrate the conceptual HIT/HIE landscape:



The concepts depicted in this diagram include the following:

1. Local HIOs, health systems, and other organizations provide HIT services and HIE coverage to some providers.
2. Statewide Direct secure messaging provides a foundation for sharing information across organizations and differing technologies. HISPs allow practices and hospitals to participate in Directed exchange from their EHRs. Note that HISP participation in common trust communities are key to this interoperability, and are not reflected in the diagram above.
3. CareAccord® provides common services as baseline HIE capabilities to those without access to local or health system HIEs, specifically providing Direct secure messaging for those without access to the HIE landscape (in the diagram, CareAccord® is represented as a HISP).
4. Statewide enabling infrastructure ties local efforts together, enabling exchange and HIT functions (such as identifying providers or locating patient records) across local HIEs, health systems and other entities. (Note: “Enabling Protocols” is a convenient way to refer to the set of mechanisms supported by each piece of enabling infrastructure for interactions.)

The DHS/OHA 2009-2015 technology plan

The DHS/OHA Information Technology Governance Council has adopted a vision of rational, service-based architecture for State IT systems, which seeks to enable enterprise capabilities to facilitate interoperability, data management and collaboration. This vision is contained in the DHS/OHS 2009-2015 Technology Plan, and includes an Enterprise Service Bus, Master Client and Provider indices, and other functionalities. Oregon sees the Medicaid HIT planning effort as a substantial driver towards achieving the Medicaid related portion of Oregon’s vision of a seamless health and human services delivery model and enterprise architecture. Future SMHP updates will describe these efforts in more detail.

The creation of the OHA set the stage for the governance and shared services that will allow Oregon to create the interoperability required to implement the MITA 2.0 framework for its Medicaid enterprise and to implement its 2009-2015 technology plan. The technology plan encompasses health insurance, federal financial and medical assistance programs, Women Infants and Children, and child welfare delivery.

The DHS/OHA 2009-2015 Technology Plan details how Oregon will integrate master data management services to connect the many systems of care. The ultimate goal is to provide a coordinated, consistent delivery of health and human services enabled by an IT infrastructure that supports improved outcomes by providing a comprehensive view of the clients and populations the State serves. The siloed systems will give way to a business architecture that provides stakeholders with a modular, functional view of human services business operations that is person-centric and service-oriented, in contrast to the prevailing program-centric organizational structure. This master data management services approach is the proposed solution for integrating the disparate data sources currently in place within the organization, and to thereby provide a more holistic view of the data, along with data governance provisions.

3. HOW WILL MEDICAID PROVIDERS INTERFACE WITH THE SMA IT SYSTEM AS IT RELATES TO THE EHR INCENTIVE PROGRAM (REGISTRATION, REPORTING OF MU DATA, ETC.)?

State Level Registry: MAPIR

Providers register and attest for the EHR Incentive Program via the MMIS Provider Web Portal, through the Medical Assistance Provider Incentive Repository (MAPIR), to attest to their eligibility for incentives. MAPIR was built under contract with Hewlett Packard (HP) through a collaborative of 13 states. MAPIR has been updated to address Meaningful Use (MU) Stage 1 and Stage 2 changes, including acceptance of MU attestation data. See Section C.14 for further detail regarding MAPIR and the State Level Registry (SLR). See section A.8 for further detail regarding the MMIS and CareAccord®.

Oregon has fully implemented all changes related to Adopt, Implement and Upgrade (AIU), and Stage 1, including changes January 1, 2013 based on the Stage 2 final regulation relating to Stage 1. Oregon will submit an update to this SMHP for MU Stage 2 SLR changes and any relevant changes to the audit strategy prior to the end of quarter two of Federal Fiscal Year 2014.

Meaningful Use

For additional information on MAPIR and on public health measures, see Section C.12. For clinical quality metrics (CQMs), EPs and EHs will transition to submitting CQMs electronically with the implementation of OHA's clinical quality metrics registry (CQMR), as described in Section A.9 and C.12.

Privacy and security planning

OHA continues to work with legal consultants and subject matter experts to evaluate and propose privacy and security policies. Deliverables may include in Phase 2.0, updates to CareAccord® and other data use agreements and other legal documents, as well as policies and recommending changes to existing State laws, regulations and policies.

4. GIVEN WHAT IS KNOWN ABOUT HIE GOVERNANCE STRUCTURES CURRENTLY IN PLACE, WHAT SHOULD BE IN PLACE BY 5 YEARS FROM NOW IN ORDER TO ACHIEVE THE SMA'S HIT/E GOALS AND OBJECTIVES? WHILE WE DO NOT EXPECT THE SMA TO KNOW THE SPECIFIC ORGANIZATIONS WILL BE INVOLVED, ETC., WE WOULD APPRECIATE A DISCUSSION OF THIS IN THE CONTEXT OF WHAT IS MISSING TODAY THAT WOULD NEED TO BE IN PLACE FIVE YEARS FROM NOW TO ENSURE EHR ADOPTION AND MEANINGFUL USE OF EHR TECHNOLOGIES.

Current governance state

As laid out in the Business Plan Framework, currently OHA is responsible for the following governance, operations, and stakeholder convening roles:

- Providing public accountability and transparency into State efforts, including the CareAccord® program and the Medicaid EHR Incentive Program, through the stakeholder council, HITOC.

- Administering the CareAccord® program in part directly and partly through a contracted vendor. OHA chose this approach for flexibility of the current state and potential future state governance and operations. This model fully utilizes State HIE Cooperative Agreement funding through ONC, maximizes the potential of Medicaid funding (OHA is the Medicaid Agency for Oregon), and enhances the likelihood of coordination between the HIE efforts and the Medicaid EHR Incentive Payment programs.
- Convening a CCO stakeholder HIT advisory group to guide the implementation of Phase 1.5 services (started in October 2013).
- Establishing, documenting and operationalizing State policies related to HIT/HIE within federal and State parameters, including HIPAA and other federal regulatory requirements, such as 42 CFR Part 2.
- Managing the federal relationship with ONC for the ONC State HIE Cooperative Agreement and CMS for the EHR Incentive Program, as well as assuring federal compliance.

Considerations for future state

As a part of the stakeholder process, the HIT Task Force reviewed the options for the most appropriate governance option for the State as it moves forward to its next phase. Multiple options related to HIT/HIE governance and financing were considered. As a starting point, Oregon looked to other states for models. States have chosen various models for governance, including the state establishing statewide HIT/HIE policy through a current or new state agency and operating the infrastructure, the state setting policy and a non-profit operating the infrastructure, the state in a public-private partnership setting policy and operating the infrastructure, and various combinations of the previously mentioned models.

Principles and characteristics

The HIT Task Force identified certain principles and characteristics that the Oregon governance structure must incorporate, no matter what organizational structure it takes.

- Participation and representation
- Transparency and openness
- Effectiveness
- Flexibility and accountability
- Well-defined and bounded mission

State and stakeholder roles in governance, policy and operations future state

The proposed governance structure retains the following roles for OHA. Through OHA, the State is responsible for:

- Statewide direction
- Oversight
- Accountability
- Transparency
- Setting statewide standards and policies

- Policy implementation, including compliance with federal requirements (Medicaid, HIPAA, etc.)
- Meaningful ongoing engagement with stakeholders, including convening and guiding stakeholders and technical assistance.

The State will contract with an HIT designated entity to:

- Operate the statewide HIE enabling infrastructure and existing and planned (Phase 1.5) and new Phase 2.0 services
- Contract with technology vendors to deliver services
- Coordinate with and support local efforts

To assure sustainability of the operations if the State chose to contract with another entity as the HIT designated entity, provisions would exist to allow the State to retain the relationship with the HIE vendors involved in the infrastructure and support. Stakeholders will continue to provide input and feedback on the statewide direction, standards and policies, HIE programs and enabling infrastructure, and the performance of the HIT designated entity.

Options for the type of HIT designated entity include:

- Contracted non-profit entity, under the governance of a steering committee or board of directors
- Public corporation, established in legislation, under the governance of a board of directors (example: Cover Oregon)
- Semi-independent entity (example: Patient Safety Commission)
- Special purpose non-profit (example: SAIF)

State HIT/HIE compatibility program

The ultimate responsibility for accountability for statewide HIE/HIT resides with the State. To ensure interoperability and security of information exchanged through statewide services and protect privacy, OHA will establish a new HIT/HIE compatibility program. Any entities seeking to participate in State enabling infrastructure services would need to meet HIT/HIE compatibility program expectations. Local HIE efforts who meet the criteria have increased credibility in their communities and may be able to attract providers and health system participants.

The purpose of an HIT/HIE compatibility program is to build public trust, accountability and transparency in statewide services, by:

- Ensuring interoperability so that information exchanged is useable and valuable, and enable seamless use of State services that rely on data and technology residing in multiple organizations;
- Ensuring privacy and security practices are in place; and
- Providing quality assurance.

Key features of a State HIE/HIT compatibility program include:

- Meeting core criteria and standards are a condition of participation in statewide services. Entities could operate HIE services in the state without meeting the criteria, but would not be able to participate in statewide services. Thus, the criteria are not a mandate across the state, but a voluntary condition of participation. As such, criteria may be required through participation agreements, although OHA may choose to use other more formal mechanisms to specify criteria (law, regulation).
- Any entity that participates directly in statewide services would need to meet compatibility criteria. Entities could include community exchanges, private exchanges, hosted EHRs, CCOs, health plans, HISPs, CareAccord®, etc. Entities that participate in statewide services indirectly would need to meet the participation criteria of the community or private exchange, but not necessarily the State level criteria.
- The HIT/HIE compatibility program could be carried out in a number of different ways: the program could require documentation and site visits to “accredit” entities or entities could attest to meeting standards and the State could reserve the right to validate the accuracy of the information attested. OHA could delegate the program to an external neutral entity, or could retain the program in-house.
- In addition, the State may use other accountability levers to drive toward compliance. For example, using State contracts with providers, CCOs or health plans, the State may encourage or require participation in statewide services.
- The compatibility criteria and program would be developed in 2014-2015 so they are in place when initial enabling infrastructure services are implemented.
- The HIT/HIE compatibility program would reflect federal standards for privacy and security of personal health information.
- When establishing compatibility criteria, State standards should point to national standards where they exist, and proceed cautiously when setting up new state-specific standards that may add burden.

5. WHAT SPECIFIC STEPS IS THE SMA PLANNING TO TAKE IN THE NEXT 12 MONTHS TO ENCOURAGE PROVIDER ADOPTION OF CERTIFIED EHR TECHNOLOGY?

Activities supporting providers/hospitals eligible for the Medicaid EHR Incentive Program

1. Environmental scan: Landscape Assessments/Surveys	Activity Update
Procure contractor and conduct assessments/surveys of HIT landscape related to Medicaid EHR adoption and Meaningful Use. The first survey and scan will assess technical assistance/ outreach needs of Medicaid eligible professional (EP) types and eligible hospitals (EHs). Later surveys and scans will assess other parts of the HIT landscape, such as technical capacity to support care coordination across practice settings, such as long term care, behavioral health, and dental settings.	First assessment/scan: FFY 2014, Q2.
2. Medicaid EHR incentives for eligible professionals and eligible hospitals	Activity Update
a. Program operations and policy development	

Develop and implement Medicaid EHR Incentive Program operations: create program manuals and training documentation for providers, hire and train new staff for program operations	Complete for Meaningful Use Stage 1. In process for Meaningful Use Stage 2.
Process Medicaid provider incentive applications using data provided by provider and verify provider attestations (Incentive Program Operations staff), accept any provider appeals, manage increased load on existing DMAP operation units based on incentive payment program (i.e., provider enrollment, electronic funds transfer (EFT) enrollment, Web portal user support and provider appeals)	Ongoing
Provide direct provider assistance with Medicaid EHR Incentive Program application and eligibility questions	Ongoing
Launch audit activities to audit Medicaid EHR Incentive Program incentive payments	Complete for Meaningful Use Stage 1. In process for Meaningful Use Stage 2.
Analyze and report Medicaid EHR Incentive Program activity	Ongoing
b. MAPIR	
As needed to accommodate program changes, develop and execute MMIS (HP) contract amendments, with appropriate State and CMS review	Ongoing, as needed
Configuration, integration, and testing of MAPIR core releases- including Oregon’s customization of DSS design and Claims/Panel Queries	Complete for Stage 1; ongoing for Stage 2
Develop and implement upgrades to MAPIR including, but not limited to Stage 2 Meaningful Use, and other upgrades as agreed upon by the core collaborative.	Complete for Stage 1; ongoing for Stage 2
c. Public Health Meaningful Use Objectives	
Work with Public Health programs to facilitate technical assistance and guidance development, conduct key informant interviews to identify technical assistance needs of Medicaid providers and clinics, draft technical assistance documentation where needed for programs including: Electronic Laboratory Reporting (ELR), Immunizations, Syndromic Surveillance, blood lead and cancer registries	Complete for Stage 1; ongoing for Stage 2
Coordinate with other programs to maximize learning opportunities for Medicaid providers. Train entities such as O-HITEC (Oregon’s REC) and DMAP operations units to facilitate Medicaid providers’ ability to successfully meet Public Health meaningful use requirements	Ongoing
Validate test data submissions from participating Medicaid providers, including communicating with providers, documenting processes, pilot testing receipt of HL7 messages, and validating actual submissions	Ongoing
Identify needs and opportunities for additional capacity, enhancements and staffing for ELR, Immunizations and Syndromic Surveillance to help Medicaid providers achieve meaningful use	Complete for Stage 1; ongoing for Stage 2
d. Develop system to capture Meaningful Use attestations/reporting	

Work with internal partners to consider additional strategies to collect meaningful use, e-CQMs, and other quality metrics data from Medicaid providers; identify timeline and approach for system to capture data.	Ongoing
Development and implementation of robust Meaningful Use capture system (eCQMs).	Planning and preparation for development of a Clinical Quality Metrics Registry (CQMR) is underway
Ongoing development and implementation of Meaningful Use data collection and reporting. Timeline is progressive and will be dependent on release dates of upgrades from the Core MAPIR team.	Ongoing
3. Ensuring technical assistance is available for eligible professional types and eligible hospitals	
Partner with O-HITEC and other entities on availability of currently funded technical assistance for eligible professional (EP) types and eligible hospitals (EH) in Oregon; coordinate with O-HITEC and other entities to ensure Oregon’s state-specific program requirements are communicated effectively	Ongoing
Contract for REC-like services for Medicaid EP types and EHs to ensure that technical assistance/outreach is available to support Medicaid providers with EHR adoption and Meaningful Use, including use of Direct secure messaging, practice-level workflow issues, and accurate capture and reporting of clinical quality measures	Plan to launch in summer 2014
4. Direct educational and provider outreach	
Maintain and update Medicaid EHR Incentive Program and affiliated websites, including FAQs	Ongoing
Deliver presentations at meetings and conferences	Ongoing
Conduct other outreach activities including e-mail notifications and webinars	Ongoing
Contract for REC-like services as described in subsection 3 “Ensuring technical assistance is available for EP types and EHs (immediately above)	Plan to launch in summer 2014
5. Joint work through O-HITEC and other external partners	
Coordinate with key external partners to develop consistent messaging; provide materials and participate in provider outreach opportunities led by partner organizations. Continue coordinating with O-HITEC on their ONC-funded work with primary care providers through Meaningful Use Stage 1	Ongoing
6. Other EHR adoption and strategies	
Coordinate with other departmental programs and initiatives to identify opportunities to facilitate EHR adoption and Meaningful Use; in particular, seek opportunities to leverage Oregon’s Medicaid delivery system reform efforts, including Coordinated Care Organizations (CCOs) and the Patient-Centered Primary Care Home Program (Oregon’s medical home program)	Ongoing
7. Targeting high-risk critical access hospitals that may not be eligible for incentives	

Explore partnering with O-HITEC and other organizations to assist high-risk Critical Access Hospitals (CAHs) in adopting and implementing certified EHRs and achieving Meaningful Use	Initial Work Complete
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Activities assisting Medicaid providers who are potentially non-eligible professionals/hospitals to adopt certified EHRs

1. HIT/EHRs for long-term care providers	
Use environmental scans to identify opportunities for facilitating EHR adoption for Medicaid long term care providers with a focus on Medicaid nursing facilities; monitor national efforts on EHRs for long-term care providers.	Ongoing
2. HIT/EHRs for behavioral health providers	
Coordinate efforts to understand the HIT landscape through environmental scans and promote EHR adoption for community addictions and mental health providers delivering Medicaid services; monitor national efforts on EHRs for behavioral health providers.	Ongoing
3. Develop public health system strategies	
Conduct environmental scans as needed and continue to monitor opportunities for public health to use HIE to exchange information with Medicaid providers and to support Meaningful Use.	Ongoing
Plan and prepare for development of HIE functionality to include Oregon Public Health Division.	Ongoing

Activities promoting EHR Adoption and Meaningful Use via HIT and/or HIE

1. Develop Oregon's HIT and/or HIE Services	
Develop, implement and operate Oregon's new near-term HIT/HIE (Phase 1.5) services. See timeline in Section E.1.	Ongoing
2. Facilitate robust participation by Oregon/Medicaid (OHA) systems in HIT and/or HIE services	
Develop strategy for Medicaid-related State systems to participate in State HIE; ensure OHA program staff participate in development and design of core HIE services to ensure that State perspective is represented. Oregon Medicaid staff has CareAccord accounts to enable use of Direct secure messaging for prior authorizations and appeals. On November 26, 2013, CMS approved an MMIS Operations and Maintenance APD-U for CareAccord operations. (See Appendix G for CMS approval letter.)	Ongoing
Support development of policies and procedures to allow State agencies to register for State HIE accounts. As of fall 2013, some state staff in Medicaid and Public Health have CareAccord® accounts, and additional needs are being considered.	Ongoing

6. IF THE STATE HAS FQHCs WITH HRSA HIT/EHR FUNDING, HOW WILL THOSE RESOURCES AND EXPERIENCES BE LEVERAGED BY THE SMA TO ENCOURAGE EHR ADOPTION?

As described above in Section A.3, there are several HRSA-funded HIT/EHR initiatives underway in Oregon. OCHIN is involved in most of those initiatives and provides a point of contact for coordinating activities.

7. HOW WILL THE SMA ASSESS AND/OR PROVIDE TECHNICAL ASSISTANCE TO MEDICAID PROVIDERS AROUND ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY?

Initial Technical Assistance to Providers

OHA works closely with O-HITEC to assess the technical assistance available to Medicaid providers. Oregon assesses any gaps in technical assistance and identifies strategies to fill those gaps, either directly (e.g., via public health program technical assistance regarding meeting one of the public health Meaningful Use criteria) or by enhancing the technical assistance capacities of its partners, including O-HITEC.

Expanded technical assistance/outreach to providers

Additional detail is provided in the Business Plan Framework (Appendix A); however, a current need identified is that without workflow changes at the practice level, the benefits of EHRs and HIT/HIE services will not be realized. Providers need support and technical assistance to integrate information technology into their workflow. To ensure providers can access EHR incentive payments, providing technical assistance to Medicaid providers is required.

Communication and outreach are also important. State efforts can include assessing and informing stakeholders about current and changing environments, convening to share best practices, and providing guidance and technical assistance on key areas.

OHA has submitted an I-APDU to seek additional Medicaid funding to provide additional technical assistance to Medicaid providers to help them meet Meaningful Use requirements while ensuring that clinical data for metrics captured in EHRs are accurate and complete. Technical assistance contracts are anticipated to be in place in 2014, contingent upon CMS funding and approval.

Approach to technical assistance/outreach

Landscape Assessments: Before launching technical assistance/outreach services, Oregon plans to contract for landscape assessments of technical assistance needs of Medicaid EP types and EHRs in each geographic area of the state, with the geographic areas corresponding to the service areas of Oregon's Medicaid Coordinated Care Organizations (CCOs). The assessments will enable Oregon to target technical assistance/outreach services to best meet needs at the provider, regional and state level.

Technical Assistance/Outreach Approach: OHA will contract for one or more entities to provide technical assistance/outreach services. The first deliverable under the contract(s) will be to develop work plans (which must be approved by the OHA) for delivery of technical assistance based on the landscape assessments of each region's needs.

Technical Assistance/Outreach Payment: Oregon considered tying contract payments to milestones similar to those used by the Office of the National Coordinator for Health IT (ONC) in the Regional Extension Center (REC) program. ONC’s REC program has a performance-based reimbursement structure that compensates REC grantees for assisting primary care providers through three milestones: (1) a health care provider enrolls to receive assistance from a REC; (2) the provider “goes live” with an EHR that has e-prescribing and quality reporting functionalities enabled; and (3) the provider or REC attests that the provider has met the Medicare and Medicaid EHR Incentive Program criteria for Meaningful Use of an EHR. Those milestones, however, are not flexible enough to meet the varied technical assistance/outreach needs existing across the state today.

To tailor milestones/deliverables to current needs, milestones and deliverables for payment will be based on the work plans. These could include measures of Medicaid EP types and EHs

- Adopting, implementing and upgrading certified EHRs,
- Ready to use Direct secure messaging to meet the Meaningful Use Stage 2 transitions of care measures,
- Successfully reporting clinical quality measures (CQMs) for Meaningful Use and OHA’s quality incentives for CCOs,
- Meeting Meaningful use Stage 1, and
- Meeting Meaningful use Stage 2.

Oregon will work with CMS throughout the contracting process and the setting of milestones and deliverables to ensure that appropriate measures of accountability are in place.

8. HOW WILL THE SMA ASSURE THAT POPULATIONS WITH UNIQUE NEEDS, SUCH AS CHILDREN, ARE APPROPRIATELY ADDRESSED BY THE EHR INCENTIVE PROGRAM?

Serving populations with unique needs

Efforts to facilitate EHR adoption and Meaningful Use cannot be focused only on easy-to-reach and easy-to-serve populations. In fact, certain groups have an even greater need for coordinated care than others. As stated in Oregon’s HIE Strategic Plan, Oregon’s HIE strategy will keep these groups in mind at each stage of planning and implementation. Oregon’s HIT/HIE efforts focus first on Medicaid providers and the Coordinated Care Organizations (CCOs) who serve nearly all Medicaid beneficiaries in the state, including Medicaid beneficiaries who are:

- Medically underserved,
- Newborns and children,
- Elderly or disabled,
- Those with mental and substance abuse disorders, and/or
- American Indians and Alaskan Natives.

Long term care HIT plan

The long term care HIT plan (to be included in a later update to Oregon’s SMHP) will focus on exploring activities to encourage or facilitate adoption and Meaningful Use of certified EHRs for Medicaid long term care facilities in Oregon. Activities include an environmental scan of nursing

facilities' use of EHRs, coordinating with stakeholders to identify other opportunities for facilitating EHR adoption. To facilitate this work and other work related to long-term care and HIT, OHA's Office of HIT coordinates with the DHS Aged and Persons with Disabilities Division. The engagement of long term care facilities is critical as EPs and EHs seek to address transitions of care and continuity of care records. OHA's HIT/HIE efforts will include connecting long term care facilities to health care teams through Direct secure messaging, including through increasing use of CareAccord® among long term care providers.

As indicated previously, CareAccord® participants already include long term care and behavioral health providers. The CareAccord® infrastructure supports patient information sharing within the physical health care system (labs, radiology, problem lists/allergies, medication lists, referrals, etc.) and across care teams (long term care, behavioral health, social services, criminal justice, etc.).

Community behavioral health HIT plan

The community behavioral health HIT plans (to be included in a later update to Oregon's SMHP) will focus on activities to promote EHR adoption for community addictions and mental health providers delivering Medicaid services. Activities include use of EHRs including OWITS (see Section A.11) and feasibility going forward, working with OHA's HIT/HIE efforts to develop behavioral health components, including facilitating the use of Direct secure messaging across behavioral health providers, and working to address and clarify HIPAA and 42 CFR Part 2 issues. To facilitate this work and other work related to community behavioral health and HIT, the OHA's HIT Policy and Program Steering Committee includes a representative from OHA's Addictions and Mental Health Division.

9. IF THE STATE INCLUDED IN A DESCRIPTION OF A HIT-RELATED GRANT AWARD (OR AWARDS) IN SECTION A, TO THE EXTENT KNOWN, HOW WILL THAT GRANT, OR GRANTS, BE LEVERAGED FOR IMPLEMENTING THE EHR INCENTIVE PROGRAM, E.G. ACTUAL GRANT PRODUCTS, KNOWLEDGE/LESSONS LEARNED, STAKEHOLDER RELATIONSHIPS, GOVERNANCE STRUCTURES, LEGAL/CONSENT POLICIES AND AGREEMENTS, ETC.?

CHIPRA Consortium

The Oregon-led Tri-state consortium received \$2,231,890 for the first year of a five-year grant that totals \$11,277,361 to demonstrate the combined impact of patient-centered care delivery models and health information technology in improving the quality of children's health care. The work included the development and validation of quality measures, improvement of infrastructure for electronic or personal health records utilizing health information exchanges, and implementation and evaluation of medical home and care coordination models (CCOs in Oregon).

Alaska, along with Oregon, is also a member of NATE (see Section A.13). Joint participation in NATE and CHIPRA allowed Oregon and Alaska to leveraged knowledge gained across initiatives. Oregon has also leveraged its CHIPRA quality demonstration experience in its efforts to support CCOs. For example, the Oregon Transformation Center, which supports CCOs through technical

assistance and learning collaboratives, sponsored a learning collaborative aimed at connecting child health providers with early education providers. The State's experience in the CHIPRA quality demonstration informed that planning process.²⁹

Oregon's experience with producing quality measure data using the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) has given the State a better understanding of the utility of those measures. Oregon applied that insight in its discussions with CMS around the identification of the measures that should be produced and evaluated to determine effectiveness for its CCO demonstration waiver.

Medicaid Transformation Grant

The Medicaid Transformation Grant funding ended in 2011. The components were designed to facilitate EHR adoption and Meaningful Use (including electronic submission to the immunization registry), and facilitated Oregon's HIT and HIE planning and development as those efforts moved forward. The HIT enhancements, such as the immunization information system's bidirectional web services interface is a part of the "As-Is" environment. The information policy and business analysis efforts began to address some of the issues the State is still grappling with today, such as adolescent data.

Health Insurance Marketplace

Oregon's Health Insurance Marketplace (called Cover Oregon) and eligibility and enrollment modernization projects form a framework for achieving several of the IT goals in the DHS/OHA IT Technology plan and provide the basis for broader service-oriented architecture that will benefit other State systems and Medicaid-related programs. Oregon's Health Insurance Marketplace is in the implementation stage. OHIT staff have had initial discussions with Cover Oregon staff regarding opportunities to leverage new state-level HIT/HIE services (including Phase 1.5 services) to support Cover Oregon, and vice versa. However, discussions have been put on hold until Cover Oregon's website is fully operational.

10. DOES THE SMA ANTICIPATE THE NEED FOR NEW OR STATE LEGISLATION OR CHANGES TO EXISTING STATE LAWS IN ORDER TO IMPLEMENT THE EHR INCENTIVE PROGRAM AND/OR FACILITATE A SUCCESSFUL EHR INCENTIVE PROGRAM (E.G. STATE LAWS THAT MAY RESTRICT THE EXCHANGE OF CERTAIN KINDS OF HEALTH INFORMATION)? PLEASE DESCRIBE.

As OHA's long-term HIT/HIE plans anticipate facilitating query as well as Direct secure messaging, OHA is planning and preparing for the relevant data exchange accommodations that must be considered, including but not limited to consent and data privacy and security. At this time, no specific state legislative authority is anticipated but as OHA works with stakeholders to develop and implement HIT/HIE efforts, policy and regulatory issues that are identified will be addressed.

²⁹ <http://www.urban.org/publications/1001700.html>

The plans for a new HIT/HIE compatibility program may or may not require new legislative authority and may be accommodated through contractual language. The only currently identified area where State authority is lacking is the authority to collect fees.

SECTION C: ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE EHR INCENTIVE PAYMENT PROGRAM

1. HOW WILL THE SMA VERIFY THAT PROVIDERS ARE NOT SANCTIONED, ARE PROPERLY LICENSED/QUALIFIED PROVIDERS?

Oregon uses several approaches to these verifications; all license and sanctions checks precede payment. As part of the attestation, the provider attests within the MAPIR application to being properly licensed and not sanctioned by professional boards in any of the states in which they practice and/or at the federal level.

The National Level Repository (NLR) performs a verification of sanctions at the federal level. At the initial part of the application process, MAPIR interfaces with the NLR and receives any information regarding federal sanctions.

Incentive program staff checks licenses after a completed application has been submitted. There are multiple licensing boards in Oregon, which provide web site license look-ups allowing multiple search options. The Medicaid EHR Incentive Program verifies the provider has an active license and is not sanctioned by entering the license number in the license look-ups. The Oregon license check is completed and the results documented by the incentive program staff processing the application.

If the license is active in Oregon without sanctions, there is an automated check against the NLR for a second time preceding payment to see if there are any federal sanctions or sanctions taken in other states.

Providers who are licensed and without sanctions proceed through the programmatic process. Providers who are not licensed and/or have sanctions in another state and/or at the federal level are sent a denial letter for participation in Oregon's Medicaid EHR Incentive Program.

2. HOW WILL THE SMA VERIFY WHETHER EPS ARE HOSPITAL BASED OR NOT?

The provider must attest to a question in the MAPIR application asking if they are hospital-based and respond with a "yes" or "no" answer. The incentive program staff reviews the provider's MMIS service code locations for the 90-day period they are using for their patient volume calculation to verify the provider is not hospital-based. This number is then compared to proxy data averages to make a determination if more information is needed from the provider to verify they are not hospital-based. If the provider appears from the MMIS data to be hospital-based, incentive program staff contacts the provider. The provider then may send a

report showing place of service and encounter data, which incentive program staff verifies through MMIS.

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4. HOW WILL THE SMA COMMUNICATE TO ITS PROVIDERS REGARDING THEIR ELIGIBILITY, PAYMENTS, ETC.?

Overall approach to communications

Health care providers in Oregon may be eligible for the Medicaid EHR Incentive Program and the Medicare EHR Incentive Program. Although the focus of the Medicaid EHR Incentive Program is providers who are potentially eligible for Medicaid incentive payments, the Medicaid eligibility criteria are steep. Many Oregon Medicaid providers are not eligible for a Medicaid incentive, but may be eligible under the Medicare incentive program. However, any Oregon provider may look to OHA for information about the EHR incentive programs, so communication is directed to as wide an audience of Oregon providers as possible and attempts to provide providers information relative to both programs as much as possible.

In the fall of 2013, OHA obtained CMS's approval to enter into a contract with Brink Communications, LLC. Brink is supporting OHIT in updating its communications strategies.

Communications specific to providers' incentive applications

As needed, OHA communicates directly with providers about incentive applications. In Oregon's experience, most applications require some additional clarification or documentation; after providers submit their applications, incentive program staff communicates with providers to obtain any clarifications or any additional documentation needed. Communication occurs through various methods, such as telephone, email and fax, as the incentive program staff adjusts to best meet each specific provider's communications needs.

MAPIR sends automated emails triggered during specific steps in the programmatic process. Each email contains information notifying the provider of the step that occurred, the time-period anticipated for the event to take place, and contact information to speak with program staff. Such automated emails include, but are not limited to, notifying providers of acceptance of their application, their payment is to be processed, and their payment was processed.

Communication of general program information

General program information is currently available on Oregon's Medicaid EHR Incentive Program website at www.MedicaidEHRIncentives.oregon.gov, which includes information and links to the Medicare EHR Incentive Program. The site provides information about program eligibility, EHR certification criteria, incentive amounts, hospital payment structure, meaningful

use, and specific instructions on how to apply for the program in Oregon. Manuals for eligible professionals, eligible professionals who practice predominantly in an FQHC or RHC, and eligible hospitals are posted on the website. The site is changed as program decisions are updated. A frequently asked questions feature is actively monitored and augmented as new questions surrounding the program emerge. Links to CMS, O-HITEC, ONC, and other related web sites are included. The public can e-subscribe to receive notice of updates to the web site.

Oregon also communicates with providers using a variety of additional methods, including a listserv, stakeholder lists, and the monthly “Provider Matters” newsletter of the Division of Medical Assistance Program (DMAP).

In addition, Oregon leverages key partner organizations to communicate to providers about incentives and other HIT/HIE initiatives. Organizations include Medicaid contractors, provider associations, and others. To produce a successful, comprehensive, coordinated communication strategy, it is essential to ensure that provider communications from OHA, as well as key external partners, about the incentive program complement and build on consistent messaging. Communication tools focus on the distribution of the three core messaging processes:

- Communicate about the incentive program – including program information and links to CMS for specifics including Meaningful Use criteria and Medicaid incentives;
- Connect providers to O-HITEC for technical assistance; O-HITEC, a division of OCHIN, is funded by the Office of the National Coordinator for Health IT (ONC) to help providers eligible for the incentive programs adopt and implement EHRs; and
- Provide updates on Oregon’s Medicaid EHR Incentive Program including any Oregon-specific decisions when available.

Oregon works with professional associations to target information to providers. For example, Oregon has partnered with the Oregon Association of Hospitals and Health Systems (OAHHS) to educate hospitals regarding the details of the patient volume requirements. Analysis of Oregon hospital eligibility was shared and discussed with OAHHS and with Oregon’s hospitals. In addition, Oregon’s incentive program staff works with the Regional Extension Center, O-HITEC, for clear messaging. As opportunities arise, incentive program staff present at meetings, such as the rural hospital section meeting, OAHHS technical advisory committee, and the Healthcare Financial Management Association meeting for hospital and other health care financial managers.

5. WHAT METHODOLOGY WILL THE SMA USE TO CALCULATE PATIENT VOLUME?

Oregon decisions affecting patient volume

Oregon adopted both the patient encounter and patient panel methodologies giving the greatest flexibility for Oregon providers to qualify for incentive payments. The patient panel methodology must apply to both individual patient volume calculations, as well as to group patient volume calculations; MAPIR accommodates both.

In addition, Oregon has chosen to allow providers to include out-of-state Medicaid patients towards patient volume to increase the eligibility of providers for incentive payments. To verify the out-of-state patient data, Oregon communicates with its border states via email and telephone as needed.

Oregon is interested in ideas for alternate methodologies that would allow more professionals to become eligible for incentives. Oregon will continue to explore ideas for an alternate methodology for future years of the program.

Oregon Health Plan: CHIP and Medicaid patients are indistinguishable to providers

Oregon has made substantial progress in streamlining State health care programs, including Medicaid and CHIP, into one program: the Oregon Health Plan. Beneficiaries and providers have no clear indication to which program the patient is enrolled. Since eligibility for incentives is based on Medicaid patient volume, and does not include CHIP patients, providers will be unable to determine their Medicaid patient volume without relying on guidance from Oregon's EHR incentive program staff. Oregon's MMIS system differentiates the paying source using detailed codes for eligibility that can be easily traceable to the claim.

To address this issue, Oregon uses the following "CHIP proxy" strategy to address this issue and provide ways for providers to determine Medicaid patient volume: Identify an average proportion of CHIP encounters out of all encounters, called a "CHIP proxy." Providers will identify their total Oregon Health Plan patient volume and reduce by the CHIP proxy when applying for incentives. Using this method benefits some providers whose actual CHIP patient encounters are higher than the statewide average, and may disadvantage those whose CHIP volume is lower than average. However, any provider who believes they may meet the Medicaid patient volume threshold, but does not meet the threshold after reducing their Oregon Health Plan by the statewide CHIP proxy, can work with program staff to analyze and report their actual data. Incentive program staff will use the state proxy along with MMIS data to verify the Medicaid patient volume.

Some incentive payments will be selected for an audit. For providers using the CHIP proxy, the auditor will assess whether the total Oregon Health Plan encounters were accurately represented, and will not attempt to evaluate a provider's actual Medicaid-only encounters. Thus, there would be no penalty for providers who have an actual CHIP patient volume higher than the statewide proxy. For providers who request their specific data, the audit will assess whether the Medicaid encounters were accurately represented, given the information provided by the State. For example, if the State makes an error in the number of CHIP encounters, the provider would not be liable for any implications of that error.

Oregon uses one proxy of 4.4% to apply to both eligible professionals and hospitals when calculating the Medicaid patient volume. This proxy is derived from the following calculations of statewide CHIP proportion of Oregon Health Plan encounters:

- 4.36% for all provider claims except where the billing provider is a hospital. Because Oregon expects many eligible professionals to use a group patient volume calculation,

which includes all billing and ancillary providers, Oregon is planning to use all provider claims except hospitals in the calculation of the statewide CHIP proportion of OHP encounters.

- 4.45% for hospitals, using the same methodology by calculating all encounters where the billing provider is a hospital.

For example:

- Provider A has 500 Oregon Health Plan patient encounters and 1200 total patient encounters.
- Oregon has an average of 4.4% CHIP-to-total Oregon Health Plan encounters.
- Provider A must reduce its Oregon Health Plan encounters by 4.4% and attest to the resulting number: 478, or 40%.
- Providers who are unable to meet the 30% patient volume with this reduction, but believe that they could meet it otherwise, can provide their total number of encounters request the State provide the specific number of CHIP encounters for the 90-day period of their choosing.

Communications with providers about the CHIP proxy

Oregon carefully explains the CHIP proxy approach to providers. The program uses language such as the following in communications with providers:

OHA wants to work with eligible professionals to ensure that every eligible provider who wants to participate in the incentive program can qualify. Part of qualification is determination of Medicaid patient volume, which must be at least 30% (20% for pediatricians). Because providers will not know which patients are enrolled in the CHIP program, there are two options for calculating patient volume.

The first option uses a statewide CHIP proxy in the calculation. OHA has determined that, on average, CHIP patient encounters are 4.4% of OHP encounters statewide. [*Will outline next steps.*] Most providers who are eligible will be able to attest to having at least 30% Medicaid patient volume with this method. [*Mention audit process.*]

However, if you think that you do have 30% Medicaid patient volume, but the above calculation does not show that, OHA staff can work with you to carry out a personalized analysis of your Medicaid and CHIP patient volume using State data. Contact the Medicaid EHR Incentive Program staff [*include email and phone numbers*].

Oregon's patient volume methodologies

Oregon's patient volume methodologies are set out in regulations at Oregon Administrative Rules (OAR) 410-165-0060, <http://www.dhs.state.or.us/policy/healthplan/guides/mehri/main.html>.

Eligible Professionals

An eligible professional must calculate patient volume by using the patient volume calculation method either of patient encounter or of patient panel. An eligible professional must calculate patient volume by using either the patient volume of the eligible professional or the patient volume of the group.

Eligible Professionals Medicaid Patient Volume Calculation Methods

An eligible professional's patient volume must be calculated using one of these four methods.

1) The patient encounter calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional must divide the total Medicaid encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period in the preceding calendar year; or

(ii) For program year 2013 and later, the eligible professional must divide the total Medicaid encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period either in the preceding calendar year or in the twelve month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

2) The patient encounter calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional must divide the group's total Medicaid encounters by the group's total patient encounters in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, the eligible professional must divide the group's total Medicaid encounters by the group's total patient encounters in any representative, continuous 90-day period either in the preceding calendar year or in the twelve month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

3) The patient panel calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012 the eligible professional must:

(I) Add the total Medicaid patients assigned to the eligible professional's panel in any representative 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the eligible professional's unduplicated Medicaid encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in (1)(d)(C)(i)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period;

(ii) For program year 2013 and later, the eligible professional must:

(I) Add the total Medicaid patients assigned to the eligible professional's panel in any representative 90-day period in either the preceding calendar year or during the 12

month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the eligible professional's unduplicated Medicaid encounters rendered same 90-day period; and

(II) Divide the result calculated above in (1)(d)(C)(ii)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

4) The patient panel calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012 the eligible professional must:

(I) Add the total Medicaid patients assigned to the group's panel in any representative 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the group's unduplicated Medicaid encounters in the same 90-day period; and

(II) Divide the result calculated above in (1)(d)(D)(i)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period;

(ii) For program year 2013 and later, the eligible professional must:

(I) Add the total Medicaid patients assigned to the group's panel in any representative 90-day period in either the preceding calendar year or during the 12 month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the group's unduplicated Medicaid encounters that same 90-day period; and

(II) Divide the result calculated above in (1)(d)(D)(ii)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

Eligible Professionals Practicing Predominately in an FQHC or RHC Patient Volume Calculation Methods

An eligible professional who practices predominantly in an FQHC or an RHC must have a minimum of 30 percent patient volume attributable to needy individuals.

An eligible professional's needy individual patient volume must be calculated using one of the following methods.

1) The patient encounter calculation method based on the patient volume of the eligible professional:

- (i) For program year 2011 or 2012, the eligible professional must divide the total needy individual encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90 day period in the preceding calendar year;
- (ii) For program year 2013 and later, the eligible professional must divide the total needy individual encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period either in the preceding calendar year or in the twelve month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years;

2) The patient encounter calculation method based on the patient volume of the group requires that:

- (i) For program year 2011 or 2012, the eligible professional must divide the group's total needy individual encounters by the group's total patient encounters in any representative, continuous 90-day period in the preceding calendar year;
- (ii) For program year 2013 and later, the eligible professional must divide the group's total needy individual encounters by the group's total patient encounters in any representative, continuous 90-day period either in the preceding calendar year or in the twelve month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

3) The patient panel calculation method based on the patient volume of the eligible professional requires that:

- (i) For program year 2011 or 2012, the eligible professional must:
 - (I) Add the total needy individual patients assigned to the eligible professional's panel in any representative 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the eligible professional's unduplicated needy individual encounters rendered in the same 90-day period; and
 - (II) Divide the result calculated above in (1)(d)(C)(i)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.
- (ii) For program year 2013 and later, the eligible professional must:
 - (I) Add the total needy individual patients assigned to the eligible professional's panel in any representative 90-day period either in the preceding calendar year or during the twelve month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the eligible professional's unduplicated needy individual encounters rendered same 90-day period; and

- (II) Divide the result calculated above in (1)(d)(C)(ii)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and
- (III) Not use the same 90-day timeframe to calculate patient volume in different program years.

4) The patient panel calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012 the eligible professional must:

- (I) Add the total needy individual patients assigned to the group's panel in any representative 90-day period in the prior calendar year, provided at least one needy individual encounter took place with the patient in the preceding calendar year, to the group's unduplicated Medicaid encounters in the same 90-day period; and
- (II) Divide the result calculated above in (1)(d)(D)(i)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period;

(ii) For program year 2013 and later, the eligible professional must:

- (I) Add the total needy individual patients assigned to the group's panel in any representative 90-day period either in the preceding calendar year or during the twelve month timeframe preceding the attestation date, provided at least one needy individual encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the group's unduplicated Medicaid encounters that same 90-day period; and
- (II) Divide the result calculated above in (1)(d)(D)(ii)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and
- (III) Not use the same 90-day timeframe to calculate patient volume in different program years.

Eligible Hospitals (Acute Care Hospitals) Medicaid Patient Volume Calculation Methods

If an eligible hospital is an acute care hospital, it must calculate patient volume by dividing the total eligible hospital Medicaid encounters by the total encounters in any representative, continuous 90-day period:

(A) For program year 2011 and 2012, in the preceding federal fiscal year;

(B) For program year 2013 and later, either in the preceding federal fiscal year or in the twelve month timeframe preceding the attestation date. The eligible hospital may not use the same 90-day timeframe to calculate patient volume in different program years.

6. WHAT DATA SOURCES WILL THE SMA USE TO VERIFY PATIENT VOLUME FOR EPS AND ACUTE CARE HOSPITALS?

Patient volume for eligible hospitals

Hospital patient volume is verified using MMIS prior to a payment being distributed. Hospitals must meet a Medicaid patient volume of at least 10%. Incentive program staff compares data on the hospital attestation to data generated by validated queries of the MMIS. If the attestation is within a variance of 20% of the MMIS data, then the attested patient volume is used to verify patient volume. However, if the attestation is outside of the 20% variance allowable by Oregon EHR Incentive Program rules, then staff will work with the provider to obtain a Patient Volume System Report. The system report will be compared to the MMIS data to locate the cause of the variance and any issues will be resolved until the attestation can be brought within the allowable variance and verified for patient volume requirements. Any documentation provided by the hospital, including the system report and any reconciliation reporting is uploaded into MAPIR as part of the attestation for use during any future review. In addition to the patient volume, staff verifies average length of stay by dividing total bed days by total hospital discharges for the program year.

Patient volume for eligible professionals

To collect patient volume information from applicants, the MAPIR application pulls each provider location associated with the applicant's NPI. The applicant enters the numerator and denominator patient volume data per location for a 90-day period in MAPIR.

Medicaid encounters

Applicants are required to separately enter their Medicaid encounters for in-state Medicaid, Medicaid encounters for out-of-state Medicaid, and total encounters for a 90-day period. This reported data is calculated as a percentage automatically, so applicants can see whether they meet the required proportion of Medicaid encounters.

To verify the number of Medicaid encounters, the number of Medicaid patient encounters during the 90-day period specified by the applicant is derived from MMIS and other data sources. These MMIS encounters include claims data and "shadow claims" – encounter data submitted by Medicaid managed care organizations and CCOs. Incentive program staff compares the MMIS data to the applicant's reported encounters to verify. In addition, incentive program staff may have providers submit a patient volume report or a spreadsheet capturing the provider's encounters; staff then spot check some of the encounters by comparing them to MMIS data.

Medicaid and CHIP claims not in MMIS

Most Medicaid and CHIP claims reside in Oregon's MMIS system. There is a small portion of Title XIX (Medicaid) and Title XXI (CHIP) funds that supports access to medical care that is not processed through MMIS. These other programs are CCare and the Family Health Insurance Assistance Program (FHIAP), which record data separately and have different data traceability. FHIAP ends in 2014 with the Medicaid expansion. It is Oregon's practice that if a provider does

not meet the patient volume threshold, but believes they have patients who are CCare or FHIAP recipients, the incentive program staff will work directly with the provider and the program staff to identify data sources.

The Oregon Public Health Division of OHA provides administration of the CCare program. CCare administers Medicaid funds to providers who provide family planning services. The funded services are reimbursed by the state directly to a clinic and do not tie the service to a specific provider. Incentive program staff may obtain reports of CCARE visits at the clinic level, but not the individual provider level. Clinics providing CCare services are able to connect the provider to the service and funding. The incentive program does have data to support providers using the group patient volume calculation for eligibility. However, if an eligible professional providing CCare services applies to the incentive program using the individual patient volume calculation, the provider may choose to submit acceptance documents at application to support the patient volume.

Patient panel

Program staff members anticipate that a small proportion of eligible professionals will choose the patient panel method to determine patient volume and an even smaller proportion will use group patient panel volume. Oregon's MMIS will not reflect data about patients assigned to a provider's panel. Oregon requires that specific documentation of panel size be available in the case of an audit, and encourages providers to upload documentation of panel size to the MAPIR application. Incentive payment staff cross-reference the data where possible by analyzing the number of Medicaid encounters within the prior calendar year as a proxy to verify Medicaid panel data. If a provider does not provide supporting documentation at application, Oregon will rely on its post-payment audit strategies to verify panel data.

Needy individual encounters

Needy individual encounters are verified using the following methods for each of the “needy individual” encounter types:

- Person who is receiving assistance under Title XIX (Medicaid); patient volume is verified by using MMIS data for the number of Medicaid encounters,
- Person who is receiving assistance under Title XXI (CHIP); patient volume is verified by using MMIS data for the number of CHIP encounters,
- Person who is furnished uncompensated care by the provider; patient volume is verified using reports or billing data supplied by the provider,
- Person for whom charges are reduced by the provider on a sliding scale basis based on the individual’s ability to pay; patient volume is verified using reports or billing data supplied by the provider.

Oregon uses the following methods to obtain verification sources, such as HRSA reports, for encounters related to uncompensated care and reduction of charges on a sliding scale:

- During the application process: EPs will be able to provide data by uploading it as a PDF to the MAPIR application. MMIS data is used to determine whether the EP has at least 30% Medicaid/CHIP patient volume.

Out-of-state Medicaid patients

Oregon anticipates that a number of providers will only qualify for incentive payments by including out-of-state Medicaid patients to meet the patient volume threshold. To verify the out-of-state patient data, Oregon communicates with its border states via telephone and email as needed.

7. HOW WILL THE SMA VERIFY THAT EPS AT FQHC/RHCS MEET THE PRACTICES PREDOMINATELY REQUIREMENT?

Providers must attest to a question in the MAPIR application asking if they practice predominantly in an FQHC/RHC and respond with a “yes” or “no” answer. Incentive program staff review the providers’ MMIS service code locations for the 90-day period they are using for their patient volume calculations to estimate whether the provider appeared to practice predominantly in an FQHC/RHC. MMIS data identifies providers who are unlikely to practice predominantly in an FQHC/RHC. Staff also contacts providers who attested that they practice predominantly to provide the 6 month timeframe, the number of encounters in the FQHC/RHC, and the number of encounters at all locations. Data sources used to support patient volume attestations are required to be retained for seven years.

8. HOW WILL THE SMA VERIFY ADOPT, IMPLEMENT OR UPGRADE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY BY PROVIDERS?

When providers enter an application in MAPIR, they are asked to enter their 15-digit CMS EHR Certification ID from the ONC Certified HIT Product List website. The system will perform an online validation of the CMS EHR Certification ID that was entered. At the end of the application, providers should upload documentation as proof of adopting, implementing, or upgrading to a certified EHR technology. This eligibility criterion is validated by verifying at least one of the four following types of documentation:

- Copy of a software licensing agreement
- Contract
- Invoices
- Receipt that validates the provider’s acquisition.

Vendor letters and other documents may also be submitted as a supplement to the items on the documentation list above. However, these supplemental documents will not satisfy program eligibility requirements on their own.

9. HOW WILL THE SMA VERIFY MEANINGFUL USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY FOR PROVIDERS’ SECOND PARTICIPATION YEARS?

MAPIR is used to collect attestation of Meaningful Use data. Incentive program staff checks the data provided against a staff tool with formulas and public health data source to establish that all Meaningful Use criteria are met. If needed, program staff request supporting information from providers at the prepayment verification or post-payment audit depending on the initial findings and risk-based assessment.

10. WILL THE SMA BE PROPOSING ANY CHANGES TO THE MU DEFINITION AS PERMISSIBLE PER RULE-MAKING? IF SO, PLEASE PROVIDE DETAILS ON THE EXPECTED BENEFIT TO THE MEDICAID POPULATION AS WELL AS HOW THE SMA ASSESSED THE ISSUE OF ADDITIONAL PROVIDER REPORTING AND FINANCIAL BURDEN.

Regarding a revised definition for Meaningful Use, Oregon requested approval to require the immunization registry reporting menu-set objective be reported in Stage 1. No further changes are proposed at this time.

Oregon has chosen to modify the definition of Meaningful Use per CFR 495.316 and 495.332 to require in the menu set, rather than move to Core, the immunizations public health menu measure in Stage 1 for providers. Oregon has chosen this approach to emphasize the importance of public health, and in particular immunizations, while not placing additional burden on providers. If Oregon was to modify the definition by moving the immunizations measure to Core, providers would have needed to report on an additional Core measure plus 5 menu measures. In addition, requiring the immunizations measure as one of the menu measures directs providers to submit information that is currently reportable to the State rather than allowing an exclusion to be claimed on one of the measures that is not currently reportable to the State. The Oregon decision strikes a balance between the potential for additional provider burden and making the statement during Stage 1 that public health is just as important to Meaningful Use as the other health outcomes.

Oregon's plan for stage 1 Meaningful Use is that eligible professionals will report on 15 core measures and 5 menu measures, one of which will be the immunizations measure. Eligible hospitals that are applying for Medicaid only will report on 14 core measures and 5 menu measures, one of which will be the immunizations measure. There is only one Medicaid-only hospital in Oregon, and it will not be applying for Meaningful Use until at least 2014. For program years 2012 and 2013, reporting an exclusion on the immunizations measure will count towards meeting the five total menu measures.

How providers apply using Oregon's definition

System application

Oregon's MAPIR application system does not have any logic or altered functionality to require that the immunization measure is reported for the menu set. In case a provider does report an exclusion on both public health measures, standard MAPIR programming requires that providers report on 4 additional measures. Oregon is the only state with this type of variation in policy resulting in the MAPIR collaborative not being able to make a technical accommodation

for this policy. Oregon determined a business process change would be most appropriate to address the required measure. The provider is presented with informational pages within the MAPIR application to explain the policy and provide direction. The word “core” is avoided and used the term “require” instead. In addition, Oregon providers are asked to answer the following question in the survey portion of the application:

Oregon requires Meaningful Use providers to select and report on the immunization measure from the public health Meaningful Use objectives. Please confirm that you acknowledge this requirement. (yes/no)

Programmatic information

Provider communications, such as outreach materials, MAPIR help screens, and program manuals, explain the requirement for Oregon. In addition, the Oregon Medicaid EHR Incentive team conducts a pre-payment audit to ensure that every provider who attests in Oregon will attest to the immunizations Meaningful Use measure, or attest that they qualify for an exclusion.

The Medicaid HIT Project leadership and staff worked closely with the Oregon Public Health Division and other stakeholders to weigh the costs and benefits of moving any of the four discretionary menu-set Meaningful Use objectives to the core set for Oregon. This included an evaluation of public health system readiness to accept the data and an assessment of provider burden and benefit.

Potential benefit to Medicaid population

Data in Oregon’s ALERT immunization registry are consolidated to ensure a complete, accurate record for every Oregonian, and are used to keep the population up-to-date and protected against vaccine preventable disease. The State also needs to gather this information to make policy decisions, as in times of epidemics such as H1N1. The immunization Meaningful Use requirement presents an opportunity for the state to capture data it needs to do its job for the benefit of both the public and private sectors. The Medicaid population often changes clinics and providers, and having accurate immunization records would help the individual health of Medicaid clients, as well as overall population health.

Impact to providers, including any potential barriers

To meet the immunization registry reporting objective, providers will need to configure their EHRs to transmit messages to Oregon’s registry, and some providers will need to purchase additional technical modules associated with meeting this requirement. However, providers are likely to see specific benefits related to eliminating the need for duplicate entry of immunizations, and receiving immunizations registry information electronically.

There is concern that was voiced by a few providers, that some may perceive that the elimination of choice by making immunization registry reporting a core objective would add burden to those implementing certified EHRs, while others expressed support for the recommendation.

The placement of all of the Public Health Meaningful Use objectives in the menu set, and none in core, raised concerns that Public Health needs are not central to the implementation of HIE and Meaningful Use at the federal level. By requiring one of the Public Health objectives, immunization registry reporting, be reported to the State, Oregon wants to send an unequivocal statement that Public Health needs are every bit as “core” as the objectives focusing on direct patient care.

11. HOW WILL THE SMA VERIFY PROVIDERS’ USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY?

When entering an application in MAPIR, providers will be asked to enter their 15-digit CMS EHR Certification ID from the ONC Certified HIT Product List (CHPL) website. MAPIR will perform an online validation of the CMS EHR Certification ID. Prior to submission, providers may upload meaningful use or adopt, implement, or upgrade (AIU) documentation into MAPIR. When documentation is not supplied, program staff will request the information from the provider prior to payment.

AIU documentation consists of the following types of documentation:

- Copy of a software licensing agreement
- Contract
- Invoices
- Receipt that validates the provider’s acquisition.

Meaningful use documentation consists of reports generated by certified EHR technology that display the objective measure results for the provider.

Program staff verifies the use of certified EHR technology in the following ways:

1. For providers attesting for AIU in any program year, the incentive program staff will use the CMS HITECH portal to verify that the supplied AIU documentation matches the CMS EHR Certification ID.
2. For provider attesting to meaningful use in program year 2014 and later
 - a) the incentive program staff will request AIU documentation and use the CMS HITECH portal to verify that the supplied AIU documentation matches the CMS EHR Certification ID if the provider has adopted new Certified EHR technology
 - b) meaningful use documentation.

12. HOW WILL THE SMA COLLECT PROVIDERS’ MEANINGFUL USE DATA, INCLUDING THE REPORTING OF CLINICAL QUALITY MEASURES? DOES THE STATE ENVISION DIFFERENT APPROACHES FOR THE SHORT-TERM AND A DIFFERENT APPROACH FOR THE LONGER-TERM?

Oregon uses MAPIR to collect Meaningful Use attestations. Applicants are provided a web-based application that includes a description of each Meaningful Use objective, clinical quality measure, and an associated area to attest their exclusion, or provide the required information

to satisfy the objective. Updates to MAPIR have been approved for Stage 1 Meaningful Use, for program year 2013 changes, and to accept Stage 2 Meaningful Use for program year 2014.

Providers will enter the start date of their EHR reporting period. Then, a Meaningful Use overview, or dashboard, of core and menu objectives as well as the clinical quality measures will display. Using the dashboard, providers will select measures to report. The dashboard will display Meaningful Use completion status.

For public health measures, OHA's Oregon Public Health Division (OPHD) has declared its readiness to accept data on its Meaningful Use webpage (<https://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/MeaningfulUse/Pages/index.aspx>) and established the process for Oregon providers to register their intent to attest for Meaningful Use Stage 2 public health objectives (see <https://ophdmu.health.oregon.gov/>). Immunization registry reporting, electronic lab reporting, and syndromic surveillance are accepting Stage 1 and Stage 2 data, including test data and/or working toward ongoing electronic submission. The state cancer registry and the specialized registry for blood lead level reporting (using the ELR specifications) are also ready for Stage 2.

For Stage 1 syndromic surveillance, eligible hospitals may perform tests of the certified EHR capacity to submit electronic data to Oregon ESSENCE; ongoing submissions of data are encouraged if the test is successful. To meet the Stage 2 core objective, an eligible hospital is required to submit ongoing production data to Oregon ESSENCE (i.e., for the duration of the 90 day reporting period). Oregon does not accept syndromic surveillance data from eligible providers. An exemption letter for providers is available for download.

For clinical quality measures, Oregon will transition from attestations to capturing the clinical quality metrics. To capture clinical quality measures, Oregon plans to develop a state-level clinical quality metrics registry (CQMR), with requirements to be developed and an RFP process in 2014. The registry will be State-level infrastructure necessary to submit clinical data to the State and internally utilize aggregated clinical data for quality monitoring and reporting purposes. In the near-term, the registry will support

- Meeting federal requirements for Meaningful Use incentive payments to providers, and
- Collection and calculation of CCO clinical incentive metrics (starting with the three EHR-based metrics of depression screening, poor diabetes A1c control, and hypertension).

OHA's vision is that CCOs are able to leverage certified electronic health record technology to access individual-level electronic clinical quality measure data on their beneficiaries from providers. Using electronic clinical quality measure data, CCOs have the ability to conduct analytics and performance monitoring to support population health management, care coordination activities, and develop alternate payment methodologies.

OHA recognizes that federal standards change over time, and that not all providers are in the same place when it comes to electronic health record adoption, health information exchange, and meeting Meaningful Use. OHA's goal is that Oregon providers meet Meaningful Use Stage 2

requirements and that CCOs take action to move their networked providers towards Meaningful Use Stage 2.

The registry will leverage existing efforts. Some CCOs, health plans and local entities have current or planned investments in clinical data aggregation. These local aggregators (“data intermediaries”) would submit data to the statewide registry on behalf of the providers they serve and could receive data from the registry as appropriate to feed into their analytics and quality monitoring systems. Entities without local data aggregation capability would be able to have providers submit data to the registry, and receive data from the registry related to their members and providers.

13. HOW WILL THIS DATA COLLECTION AND ANALYSIS PROCESS ALIGN WITH THE COLLECTION OF OTHER CLINICAL QUALITY MEASURES DATA, SUCH AS CHIPRA?

As noted above, Oregon will develop a clinical quality metrics registry (CQMR) with the vision that, over time, it can be used for multiple purposes. In addition to serving the Medicaid EHR Incentive Program purposes, the CQMR will serve as the repository for the three CCO quality incentive pool clinical quality metrics (CQMs). Over the longer term, the registry could be used for analyzing aggregated data to allow for the development of dashboards and benchmarks, to support health plans’ and CCOs’ efforts for better targeting of patients, and to support development of new care models and alternative payment arrangements.

14. WHAT IT, FISCAL AND COMMUNICATION SYSTEMS WILL BE USED TO IMPLEMENT THE EHR INCENTIVE PROGRAM?

Oregon uses its MMIS, including the Provider Web Portal, and MAPIR integrated into MMIS to administer its Medicaid EHR Incentive Program.

Oregon’s MMIS is CMS certified. Medicaid contracts with HP for its MMIS, which went live on December 9, 2008. Incentive payments to eligible professionals and hospitals are processed through the MMIS and all fiscal functions related to the incentive payments, such as tax reporting, are captured by the MMIS.

The Provider Web Portal

Medicaid providers seeking to participate in the EHR Incentive Program interface with the MMIS via the Provider Web Portal. Once the provider has logged into the Provider Web Portal, they select the “EHR Incentive Program” option to either initiate or continue their application for an incentive payment. Upon selecting this option they exit the Provider Web Portal and are sent to the MAPIR application where all Medicaid EHR Incentive Program functionality related to the incentive program are executed and stored.

The Provider Web Portal is a secure site that requires the user to have signed a security agreement. Online help is available to guide the user through any issues and a toll-free number is available for user support. The portal provides free, real-time information to providers and is available 24 hours a day, seven days a week, except regularly scheduled down time on the

weekend. The modifications to the Provider Web Portal to accommodate Oregon's incentive program were minimal and did not impact any other State systems. The existing security developed for the Provider Web Portal is leveraged to provide authentication such that only providers registered in the Oregon MMIS will have access to the MAPIR application. Once the provider has passed through that authentication, they will be able to enter Oregon's incentive program attestation system, MAPIR. Including MAPIR within the Provider Web Portal encourages providers to increase participation in other electronic processes that are conducted through the Provider Web Portal.

Medical Assistance Provider Incentive Repository (MAPIR)

Oregon has participated in the multi-state collaborative, Medicaid Assistance Provider Incentive Repository (MAPIR), since its inception in 2010. The core MAPIR Product is a stand-alone web-based Hewlett Packard Services (HP) application developed collaboratively and integrated into each state's MMIS. MAPIR supports the application processing for the Medicaid EHR Incentive Program. The Pennsylvania (PA) Medicaid Agency is the lead state working directly with HP and the collaborative states.

MAPIR supports in part or in whole the following aspects of professional and hospital attestation and payment processes required to carry out Oregon's Medicaid EHR Incentive program:

- Provider applicant verification,
- Provider applicant eligibility determination (including NLR confirmation),
- Provider applicant attestation,
- Provider application payee determination,
- Application submittal confirmation/electronic signature or secure confirmation,
- Medicaid payment determination (including NLR confirmation), and
- Payment generation.

In addition, MAPIR interfaces with the National Level Repository (NLR) as well as individual states' MMIS to allow providers to complete applications and generate incentive payments to eligible professionals and hospitals. MAPIR has both a provider and a user component (for use by the incentive payment staff). MAPIR is scalable to allow for growth in provider participation volume, and expansion or extensions of the Medicaid EHR Incentive Program. MAPIR is configurable to allow Oregon the flexibility to make program decisions allowed within federal regulation that may be different from the other 12 MAPIR state programs.

The following list summarizes how MAPIR fits into the larger context of State information systems:

- MAPIR interacts with the NLR to facilitate file transactions to and from CMS.
- MAPIR interacts with the Oregon MMIS (inclusive of the payment functionality within the MMIS, often referred to SMFA - Statewide Financial Management Application) for the purpose of information exchange and EHR Incentive Payment processing.
- The DHS/OHA Provider Web Portal is the security access point and gateway to MAPIR. Through the Provider Web Portal the EHR applicant accesses MAPIR.
- The MAPIR application does not interface with any other systems. MAPIR is a sub-system of the MMIS.
- All new components (hardware, software, email and licenses) that support MAPIR are not intended at this time to integrate or be integrated into any other state or federal information system.

Program application communication

Oregon has favored electronic transmission, primarily electronic mail, for all possible communications regarding the Medicaid EHR Incentive Program. In addition, Oregon uses mail

when required by state regulation, and telephone when appropriate, to communicate with providers regarding their status in the program.

In late 2013, incentive program staff registered for CareAccord® accounts, so Direct secure messaging now provides another HIPAA-compliant way for staff to communicate with providers. Beginning in January 2014, staff will begin using CareAccord® to communicate with providers whenever possible.

Provider Web Portal and MAPIR communication

Oregon uses the existing Provider Web Portal as the secure gateway to access MAPIR for enrolling prospective eligible professionals and hospitals. The MAPIR application process allows a provider to complete the full application for an incentive payment. If a provider answers questions that deems them ineligible for an incentive payment, at the end of the application the provider is presented with a review screen that has all of the potential disqualifying answers entered. The provider is then presented with three options: correct answers to application questions, submit the application with the outstanding issues, or solicit assistance by contacting incentive program staff.

15. WHAT IT SYSTEMS CHANGES ARE NEEDED BY THE SMA TO IMPLEMENT THE EHR INCENTIVE PROGRAM?

To implement Oregon's incentive program, MMIS system changes were required, including work to integrate MAPIR into Oregon's existing MMIS and Provider Web Portal. As part of this integration, Oregon developed and followed a set of state-specific MAPIR requirements. The goal for the State is to minimize customization of the MAPIR application to the extent possible, while assuring that the application is fully compliant with state statute, departmental policy, and administrative rules. However, setting up the configurable items within MAPIR to meet Oregon's requirements and some limited customization of MAPIR has been needed to implement Oregon's incentive program.

Oregon has worked closely with the MAPIR design team in Pennsylvania to ensure that the MAPIR design is flexible enough to integrate Oregon's business processes and at the same time be robust enough to support all aspects of the State's Medicaid EHR Incentive Program. Only modest changes were made to the MMIS; most adjustments related to making payments to providers via Electronic Funds Transfer. With the Provider Web Portal, the security features currently resident within the portal application were sufficient to support secure access for eligible professionals and hospitals to initiate their applications and to complete their attestations of having adopted, upgraded, or implemented EHR technology.

16. WHAT IS THE SMA'S IT TIMEFRAME FOR SYSTEMS MODIFICATIONS?

MAPIR has been successfully launched in Oregon. Over time, additional changes will be needed to adapt to evolving program requirements. The timeframe for modifications to Oregon's information systems that will support the Medicaid EHR Incentive Program will, in large part, be driven by the HP Multi-State Collaborative for MAPIR. Following each release of the application,

the core components will be integrated into Oregon's MMIS and Provider Web Portal. Program staff is trained on the use of any new data or other impacts to the process for application review, and the staff manual is updated. Once the application meets the rigors of the user acceptance test, a full integration test with the Oregon's MMIS and Provider Web Portal is executed. On the successful completion of testing the new MAPIR release is implemented, and program staff are notified to incorporate any changes to application review into their workflow per the updated staff manual.

17. WHEN DOES THE SMA ANTICIPATE BEING READY TO TEST AN INTERFACE WITH THE CMS NATIONAL LEVEL REPOSITORY (NLR)?

All MAPIR states, including Oregon, were part of CMS's Group 2 for NLR testing. HP conducted all file exchange testing between the NLR and the MAPIR application during the development of Release 1 of MAPIR. Oregon completed all of the requisite data use agreement forms and identified a state secure point of entry contact individual from the State's MMIS contractor, HP Enterprise Services, and identified a state alternate representative and completed the appropriate form for that function. NLR Interface Testing for connectivity was facilitated by the Oregon contractor, HP Enterprises, and was successfully completed in January 2011.

18. WHAT IS THE SMA'S PLAN FOR ACCEPTING THE REGISTRATION DATA FOR ITS MEDICAID PROVIDERS FROM THE CMS NLR (E.G. MAINFRAME TO MAINFRAME INTERFACE OR ANOTHER MEANS)?

The MAPIR application transmits and receives all NLR file transactions. In Oregon these transactions are interchanged between the two systems via GEN-TRAN on a daily basis, completed nightly in a scheduled series of batch executed transactions. MAPIR functionality outlined in the MAPIR Detailed Design Document and in the Detailed Technical Design delineates the hierarchy of transactions, the procedures for scheduling and initiating the transactions, and the procedures for handling error reports and potential interruptions in service. Any changes to the requirements for accepting CMS NLR registration data are handled as part of the HP Multi-State Collaborative for MAPIR.

19. WHAT KIND OF WEBSITE WILL THE SMA HOST FOR MEDICAID PROVIDERS FOR ENROLLMENT, PROGRAM INFORMATION, ETC.?

General program information is currently available on Oregon's Medicaid EHR Incentive Program website at www.MedicaidEHRIncentives.oregon.gov, which includes information and links to the Medicare EHR Incentive Program. The site provides information about program eligibility, EHR certification criteria, incentive amounts, hospital payment structure, Meaningful Use, and specific instructions on how to apply for the program in Oregon. Manuals for eligible professionals, eligible professionals who practice predominantly in an FQHC or RHC, and eligible hospitals are posted on the website. The site is changed as program decisions are updated. A frequently asked questions feature is actively monitored and augmented as new questions surrounding the program emerge. Links to CMS, O-HITEC, ONC, and other related web sites are included. The public can e-subscribe to receive notice of updates to the web site.

20. DOES THE SMA ANTICIPATE MODIFICATIONS TO THE MMIS AND IF SO, WHEN DOES THE SMA ANTICIPATE SUBMITTING AN MMIS I-APD?

Oregon has modified the MMIS to integrate MAPIR into the existing MMIS. Oregon has participated in the multi-state collaborative, Medicaid Assistance Provider Incentive Repository (MAPIR), since its inception in 2010. The core MAPIR Product is a stand-alone web-based Hewlett Packard Services (HP) application developed collaboratively and integrated into each state's MMIS. MAPIR supports the application processing for the Medicaid EHR Incentive Program. The Pennsylvania (PA) Medicaid Agency is the lead state working directly with HP and the collaborative states.

Pennsylvania received approval for its MAPIR HIT-I-APD for Phase II work, on December 21, 2011. The 13-state collaborative sought approval of \$3,869,970 (90% Federal share \$3,482,973) for activities described in Pennsylvania's I-APD for an implementation cycle from October 1, 2011 through December 31, 2012. Each state in the Collaborative was approved for \$297,690 (90% federal share \$267,921) in MMIS funds for the development of Phase II of the core MAPIR application. To rectify any confusion, CMS formally approved these funds on August 12, 2013 via Oregon's HIT I-APD-U 13- 005. The State of Oregon used its HP contract to pay HP quarterly to cover costs directly related to the core MAPIR product supported and maintained by the PA HP team.

Pennsylvania received approval for its MAPIR HIT I-APD-U for Phase III work, on November 26, 2012. The 13 state collaborative sought approval of \$5,609,104 (90% Federal share \$5,048,194) for activities described in Pennsylvania's I-APD-U for an implementation cycle from January 1, 2013 through September 30, 2014. Each state in the Collaborative was approved for \$431,470 (90% federal share \$388,323). To rectify any confusion, CMS formally approved these funds on August 12, 2013 via Oregon's HIT I-APD-U 13-005. The State of Oregon is using its HP contract to pay HP quarterly to cover costs directly related to the core MAPIR product, supported and maintained by the PA HP team.

Due to the evolving rules of the Incentive Program, MAPIR requires on-going design and development with the Collaborative. The Collaborative scope is the core MAPIR Product; this does not include scope to integrate and implement MAPIR releases in each state or any customization. Pennsylvania submits I-APDs on behalf of each Collaborative state to CMS to approve the overall funding and concept of the core MAPIR Product. States are required to individually submit I-APDs requesting funds for their portion of the core MAPIR Product, plus the integration, implementation and customization costs related to MAPIR.

It is important to note that although Pennsylvania submits the MAPIR Collaborative I-APDs on behalf of the participating states, the CMS approval letters allocate a particular portion of the approved funds per state and not the total amount to Pennsylvania. This funding award method allows Oregon to independently contract with HP to pay for the core MAPIR Collaborative Product and the Oregon integration, implementation, and customization costs. As a result, Oregon's MAPIR-related contracts with HP may include funding from separate I-APDs.

Oregon uses CMS approved funding to cover enhancements, maintenance and ongoing support for the core MAPIR product, as well as integration and customization at a local level.

21. WHAT KINDS OF CALL CENTERS/HELP DESKS AND OTHER MEANS WILL BE ESTABLISHED TO ADDRESS EP AND HOSPITAL QUESTIONS REGARDING THE INCENTIVE PROGRAM?

Support is available to assist providers with the incentive program application process. Oregon primarily relies upon incentive program staff to assist providers with incentive program questions. These are dedicated support staff who are trained to address detailed incentive program questions related to eligibility, completing Oregon's online application via MAPIR and registration with the NLR, etc. In addition, Provider Service Center and Provider Enrollment unit staff has been trained to handle the most common questions about the incentive program, and they assist providers with obtaining Web Portal access.

The Provider Enrollment unit within OHA's Division of Medical Assistance Programs (DMAP) enrolls providers such as hospitals, healthcare professionals, laboratories, managed care organizations, third-party agents and clinics. The enrollment process varies depending on the provider type, and billing and organizational structure. In the recent past, providers working for managed care organizations or FQHCs were enrolled with minimal information such as name and provider type. Starting in 2011, DMAP altered the provider enrollment process to require the National Provider Identifier (NPI) of each health care practitioner providing services under OHP regardless of organizational structure. This change directly benefits the needs of the Medicaid EHR Incentive Program to establish more information for the providers.

However, this change alone is not enough to enroll providers with complete information necessary to receive incentive payments. The incentive program staff works closely with the Provider Enrollment unit to fully enroll providers with DMAP in order to receive incentive payments. Some eligible professionals working for managed care organizations, Coordinated Care Organizations (CCOs), FQHCs, RHCs and Indian Health Services need to provide new information to Provider Enrollment to receive an incentive payment, such as tax identification number, professional license, taxonomy and practice location. This information is provided to the Provider Enrollment unit prior to application for a Medicaid EHR incentive payment. Oregon provides general and targeted provider outreach in order to disseminate appropriate information to potential eligible providers.

22. WHAT WILL THE SMA ESTABLISH AS A PROVIDER APPEAL PROCESS RELATIVE TO: A) THE INCENTIVE PAYMENTS, B) PROVIDER ELIGIBILITY DETERMINATIONS, AND C) DEMONSTRATION OF EFFORTS TO ADOPT, IMPLEMENT OR UPGRADE AND MEANINGFUL USE CERTIFIED EHR TECHNOLOGY?

The incentive program has established Oregon Administrative Rules (OAR) 410-165-0120 regarding the appeals process. That rule supplements the process outlined in OAR chapter 410, division 120.

To provide alternatives to the use of formal appeals, providers are encouraged to discuss any issues with Provider Service Unit staff and the Medicaid EHR Incentive Program staff; providers also may escalate the concern to the incentive program manager. An informal conference may be requested by the provider to give an opportunity to settle the matter without a formal appeal.

A formal decision regarding a provider's incentive payment must be made by the incentive program for the provider to submit an appeal. Formal decisions include denial of application for an incentive payment or incentive payment amount determination.

The provider may file a formal appeal by submitting the request in writing to the incentive program, DMAP or the DMAP Provider Services Unit. The provider is not required to follow a specific format as long as it provides a clear expression of the disagreement with a decision made by the Medicaid EHR Incentive Program. The provider appeal request is considered timely if received within 180 calendar days of the date of the incentive program decision. The reasons a provider can cite as basis for an appeal regarding the incentive program include, but are not limited to: an incentive payment, an incentive payment amount, a provider eligibility determination, the demonstration of adopting, implementing or upgrading, or Meaningful Use eligibility. The request should identify the decision made by the incentive program, and the reason the provider disagrees with the decision. The burden of presenting evidence to support a provider appeal is on the provider.

Provider appeals will be processed by DMAP or a party designated to review appeals independent of the Medicaid EHR Incentive Program staff. However, the incentive program staff may be consulted by the appeals reviewer to better understand complex programmatic rules. A provider appeal may be processed via written review, formal conference, administrative review, or contested case hearing depending on the nature of the appeal. Providers will be notified in writing of the date, time and location of the conference or hearing. Once the appeal is processed and a decision made, the provider will be notified in writing of the decision.

Oregon has exercised its option, pursuant to 42 CFR 495.312 and 42 CFR 495.370, to have CMS conduct the audits and handle any subsequent appeals of whether eligible hospitals are meaningful EHR users.

23. WHAT WILL BE THE PROCESS TO ASSURE THAT ALL FEDERAL FUNDING, BOTH FOR THE 100 PERCENT INCENTIVE PAYMENTS, AS WELL AS THE 90 PERCENT HIT ADMINISTRATIVE MATCH, ARE ACCOUNTED FOR SEPARATELY FOR THE HITECH PROVISIONS AND NOT REPORTED IN A COMMINGLED MANNER WITH THE ENHANCED MMIS FFP?

Oregon is committed to accurately tracking and accounting for funds and activities under its 90% match for program development, implementation, and administration and its 100% Federal Financial Participation (FFP) for incentive payments. In general, the Medicaid HIT project has financial budget codes and indexes that are used only for these funds, and keeps

them separate from other enhanced MMIS FFP. Project management routinely assesses expenditures and adjusts projections for these funds to ensure that only the appropriate funds are charged to the program. In addition, the 100% incentive payments will be made out of Oregon's MMIS, which has assigned a separate, specific code within the system to indicate that payments are for incentives. Incentive payment budgets are managed by a separate unit from the Medicaid EHR incentive program, which will manage the 90% HIT match.

24. WHAT IS THE SMA'S ANTICIPATED FREQUENCY FOR MAKING THE EHR INCENTIVE PAYMENTS (E.G. MONTHLY, SEMI-MONTHLY, ETC.)?

Using the MMIS, Oregon makes EHR incentive payments via Electronic Funds Transfer (EFT). Payments processed weekly on Fridays. MMIS processes payments on a daily cycle, and processes recoveries for outstanding debts once a week. As the EHR incentive payment is unique, not associated with a provider claim, it is anticipated that upon completion of processing of an approved Medicaid EHR Incentive Program application, acknowledgement from the National Level Repository that payment is authorized, and any and all pre-payment verifications have been completed, the payment authorization will be sent to the State Fiscal Management System, the EFT will be generated to the provider in the next scheduled weekly payment cycle (i.e. next Friday except scheduled down days), and a remittance advice will be forwarded to the provider with the details of the payment.

25. WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PROVIDER PAYMENTS ARE PAID DIRECTLY TO THE PROVIDER (OR AN EMPLOYER OR FACILITY TO WHICH THE PROVIDER HAS ASSIGNED PAYMENTS) WITHOUT ANY DEDUCTION OR REBATE?

The program will ensure that payments are not made for more than a total of six years, no provider begins receiving payments after 2016, payments cease after 2021, and that a hospital does not receive an incentive payment after FY2016 unless the hospital received a payment in the prior fiscal year. Reports utilizing data stored in MAPIR, NLR, and MMIS allow staff to track what year, what amount, and under what program payments were made based on the following processes:

- MAPIR will interact with the NLR (which tracks payments) and MMIS (which tracks payments) and compiles that information into a "record" for a specific incentive payment for an eligible professional or hospital.
- MAPIR is configurable to support the State decision on the structure for hospital payments.
- MAPIR will send hospital and EP payment calculations to the NLR which will authorize the payment and then return it to MAPIR in the interface.
- MAPIR will then send the payment transaction record to MMIS to generate the payment.
- Likewise, MMIS will send the generated payment information back to MAPIR and the cycle will repeat, alerting the NLR that a payment has been made.
- This data will be stored in MAPIR, as well as any adjustments made to payments.

- The "system of record" for EHR Payments in Oregon is the MMIS (and ultimately the NLR).

Oregon will assure that Medicaid EHR incentive payments are paid directly to the EP or an employer or facility to which the EP has assigned payments, without any reduction or rebate. Oregon will authorize the full amount of each incentive payment due to a provider and generate that payment via EFT directly to the provider (or their assignee) or hospital. Systematic and/or manual checks are in place to ensure that the EHR incentive payments are not reduced by DHS or by any other State agency so as to reconcile and/or make payment against any liens or recoupment balances. Oregon has incorporated into its post-payment audit function a review of the audited EHR incentive payments, so as to validate that the incentive payment amount calculation and the actual incentive payment made reconcile. Any discrepancies found will be addressed and resolved. These actions will be taken by Oregon to assure that all hospital and EP payments are made consistent with the Statute and regulation.

26. WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PAYMENTS GO TO AN ENTITY PROMOTING THE ADOPTION OF CERTIFIED EHR TECHNOLOGY, AS DESIGNATED BY THE STATE AND APPROVED BY THE US DHHS SECRETARY, ARE MADE ONLY IF PARTICIPATION IN SUCH A PAYMENT ARRANGEMENT IS VOLUNTARY BY THE EP AND THAT NO MORE THAN 5 PERCENT OF SUCH PAYMENTS IS RETAINED FOR COSTS UNRELATED TO EHR TECHNOLOGY ADOPTION?

CMS allows eligible professionals to voluntarily assign their incentive payments to their clinic or employer or to state-designated entities, defined in federal rule as “entities promoting the adoption of certified EHR technology.” CMS requires states to ensure that any assignments to these latter entities are made voluntarily by the eligible professional, and that no more than 5% of such payments are retained by the entity for costs unrelated to EHR technology adoption.

CMS requires “entities promoting the adoption of certified EHR technology” to be designated by the state and subsequently approved by the US DHHS Secretary, and defines their functions as:

- Enabling oversight of the business, operational and legal issues involved in the adoption and implementation of certified EHR technology or
- Enabling the exchange and use of electronic clinical and administrative data between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible professionals.

“Entities promoting the adoption of certified EHR technology” differ somewhat in purpose and function from Regional Extension Centers (RECs). RECs receive federal grant funds to provide technical assistance to primary care, small, and solo practice clinicians in selection, acquisition, implementation and Meaningful Use of certified EHR technology. Eligible professionals engage RECs and may use a portion of their incentive payment to pay for REC services, but unless a REC is state-designated as an “entity promoting the adoption of certified EHR technology,” an eligible professional may not assign their incentive payment to a REC at the time of application.

At this time, Oregon does not foresee designating any such entities in the future, but is interested in any further clarification from CMS as to the nature of these entities and their relationships with eligible professionals.

27. WHAT WILL BE THE PROCESS TO ASSURE THAT THERE ARE FISCAL ARRANGEMENTS WITH PROVIDERS TO DISBURSE INCENTIVE PAYMENTS THROUGH MEDICAID MANAGED CARE PLANS DOES NOT EXCEED 105 PERCENT OF THE CAPITATION RATE PER 42 CFR PART 438.6, AS WELL AS A METHODOLOGY FOR VERIFYING SUCH INFORMATION?

Oregon does not disburse incentive payments through Medicaid managed care plans, but will make payments directly to providers (or their assignees) and hospitals via MMIS. Due to this decision, there are no extra steps needed to assure the incentive payment for Medicaid managed care providers does not exceed 105% capitation rate.

28. WHAT WILL BE THE PROCESS TO ASSURE THAT ALL HOSPITAL CALCULATIONS AND EP PAYMENT INCENTIVES ARE MADE CONSISTENT WITH THE STATUTE AND REGULATION?

The program will ensure that payments are not made for more than a total of six years, no provider begins receiving payments after 2016, payments cease after 2021, and that a hospital does not receive an incentive payment after FY2016 unless the hospital received a payment in the prior fiscal year. Reports utilizing data stored in MAPIR, NLR, and MMIS will allow staff to track what year, what amount, and under what program payments were made based on the following processes:

- MAPIR will interact with the NLR (which tracks payments) and MMIS (which tracks payments) and compiles that information into a "record" for a specific incentive payment for an eligible professional or hospital.
- MAPIR is configurable to support the State decision on the structure for hospital payments.
- MAPIR will send hospital and EP payment calculations to the NLR which will authorize the payment and then return it to MAPIR in the interface.
- MAPIR will then send the payment transaction record to MMIS to generate the payment.
- Likewise, MMIS will send the generated payment information back to MAPIR and the cycle will repeat, alerting the NLR that a payment has been made.
- This data will be stored in MAPIR, as well as any adjustments made to payments.
- The "system of record" for EHR Payments in Oregon is the MMIS (and ultimately the NLR).

Oregon assures that Medicaid EHR incentive payments are paid directly to the EP or an employer or facility to which the EP has assigned payments, without any reduction or rebate. Oregon authorizes the full amount of each incentive payment due to a provider and generate that payment via EFT directly to the provider (or their assignee) or hospital. Systematic and/or manual checks have been put in place to ensure that the EHR incentive payments are not

reduced by DHS or by any other State agency so as to reconcile and/or make payment against any liens or recoupment balances. Oregon has incorporated into its post-payment audit function a review of the audited EHR incentive payments, so as to validate that the incentive payment amount calculation and the actual incentive payment made reconcile. Any discrepancies found will be addressed and resolved. These actions will be taken by Oregon to assure that all hospital and EP payments are made consistent with the Statute and regulation.

Verify eligible professional information

Active Oregon Medicaid provider

The existing provider information from MMIS serves as a mechanism to check that the provider is an active Medicaid provider with Oregon. The MAPIR software pulls only active providers from the MMIS.

Provider information

MAPIR captures identifying provider information which includes provider name, National Provider Identifier, Taxpayer Identification Number and National Level Registry (NLR) status. The information is cross-checked to the NLR via the MAPIR-NLR interface. If there are any discrepancies, the incentive program staff review and assess.

Participation year and program eligibility validation process

Provider eligibility, based on participation year and program is checked using NLR's program participation data. While still in development, future releases of MAPIR are expected to capture all years of participation in the EHR Incentive Program (Medicaid/Medicare), based on information transmitted to MAPIR from the NLR in the various interfaces.

Verify eligible professional practice status

Provider hospital-based EP status

As part of the pre-payment verification process, Oregon I uses data from the MMIS system to determine if the information that the EP attests to is reasonable. Oregon accesses existing data sources for more detailed checks when a threshold of reasonable comparison between MMIS and attestation date is not met. Oregon uses MMIS data to verify that less than 90% of covered services occurred in a hospital setting.

The provider must attest to a question in the MAPIR application asking if they are hospital-based and respond with a "yes" or "no" answer. The incentive program staff review the provider's MMIS service code locations for the 90-day period they are using for their patient volume calculation to verify the provider is not hospital-based. This number will then be compared to proxy data averages to make a determination if more information is needed from the provider to verify they are not hospital-based.

Hospital payment calculation

Oregon requires that the hospital attest to the necessary data elements to make the hospital payment calculation through MAPIR. Oregon will use these Medicare hospital cost reports in a pre-payment control process to verify the data elements that the hospitals have attested. The

hospital payment calculation is made during the first year of participation in the Medicaid EHR Incentive Program. MAPIR tracks the year of participation for the hospital, and indicates the payment amount for each of the three years of participation.

29. WHAT WILL BE THE ROLE OF EXISTING SMA CONTRACTORS IN IMPLEMENTING THE EHR INCENTIVE PROGRAM – SUCH AS MMIS, PBM, FISCAL AGENT, MANAGED CARE CONTRACTORS, ETC.?

The SMA has an existing contract with Hewlett Packard (HP) for the MMIS. In implementing the EHR Incentive Program, Oregon worked with HP for MAPIR and its integration into the MMIS.

30. STATES SHOULD EXPLICITLY DESCRIBE WHAT THEIR ASSUMPTIONS ARE, AND WHERE THE PATH AND TIMING OF THEIR PLANS HAVE DEPENDENCIES BASED UPON:

The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)

As noted above, Oregon's NLR Interface Testing for connectivity was facilitated by the Oregon contractor, HP Enterprises, and was successfully completed in January 2011. Provider outreach/help desk support) is critical to the success of Oregon.

The status/availability of certified EHR technology

- Provider and hospital EHR certification status continues to be uncertain, especially in the timing of upgrades to 2014-certified EHRs and decisions about mechanisms to achieve the transitions of care measures for Stage 2. With every programmatic change, it takes time to explain the program's rules to Oregon's medical community.
- Dependency on the vendors to upgrade eligible professionals' and eligible hospitals' EHRs to meet 2014 ONC certification standards. Many EPs and EHs are facing a timing issue with their technology upgrades.
- Transitioning from Stage 1 to Stage 2 for certain EPs and EHs as a result of resource issues, including staffing and financing.
- Competing agendas for many EPs and EHs, including ICD-10 and interfaces with the Health Insurance Marketplace.

The role, approved plans and status of the Regional Extension Centers

O-HITEC will educate and assist primary care providers in the adoption and implementation of certified EHR technology and Stage 1 Meaningful Use through February 2015. O-HITEC does not have funding to serve providers other than the primary care providers who have already enrolled in REC services; does not have funding to serve Medicaid specialists outside of primary care; and does not have funding to help providers with Stage 2.

The role, approved plans and status of the HIE cooperative agreements

As noted above, funding under Oregon's ONC HIE cooperative agreement expires in February 2014. The 2013 update to Oregon's strategic and operational plans is attached as Appendix C. Oregon used the cooperative agreement funding to develop the CareAccord® HIE.

CareAccord® Direct secure messaging is now being used to facilitate the exchange of information for Medicaid prior authorizations and appeals, as described above in Section A.8. Because CareAccord is being used to support the Medicaid enterprise, in November 2013, CMS approved MMIS funding for ongoing CareAccord® operations (see Appendix G for the approval letter).

State-specific readiness factors

Oregon's Medicaid EHR Incentive Program is on a fast track, and there are many interlinking activities and trends that impact one another, resulting in potential barriers or delays of this plan. Oregon is fortunate to have many factors in its favor:

- Oregon providers and hospitals continue to have a strong rate of EHR adoption.
- Oregon's participation in the MAPIR collaborative with a dozen other states allows Oregon to save time, resources, and costs; and will produce a high-quality incentive program application that meets expectations by eligible professionals and hospitals, and meets program requirements including state-specific requirements.
- Close coordination and collaboration with key stakeholders has resulted in an incentive program designed to be responsive to Oregon's specific Medicaid program environment and the needs of Oregon's eligible professionals and hospitals.
- Adoption and Meaningful Use of EHRs are key supports for health system transformation efforts, so there is great interest among Oregon's Medicaid providers.

The State also faces challenges to implementing the incentive program, many of which are common to all states creating these programs. These include the following.

- Although the program benefits from participating in the MAPIR collaborative, some additional time is needed to allow appropriate processes to incorporate the interests of all 13 states.

The State also faces challenges to implementing the incentive program due to specific circumstances of the health care delivery and Medicaid policy in Oregon. Three specific challenges are:

- Medicare Advantage is a disadvantage in Oregon: Oregon has a high rate of Medicare Advantage plans in Oregon. Providers serving Medicare patients will look to qualify for a Medicare EHR incentive payment, but will not be able to count their Medicare Advantage estimated allowed charges toward the calculation for their incentive payment.³⁰ Although incentive payments are available for Medicare Advantage organizations, most Oregon providers accept multiple Medicare Advantage plans and are not employees of a single organization. Due to these organizational and fiscal relationships, many Oregon providers will not qualify for the maximum Medicare EHR incentive payment in their first year of participation.

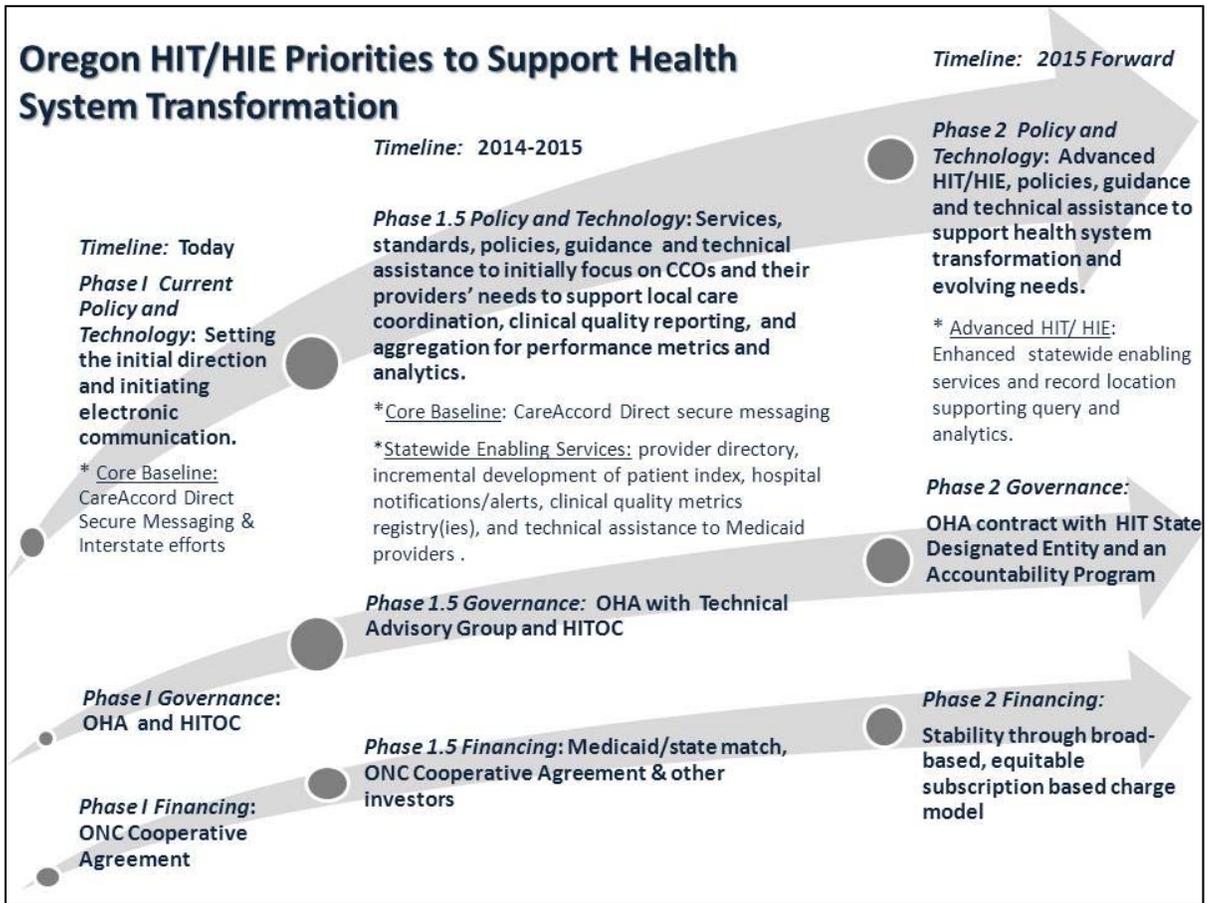
³⁰ Section 495.102 states that Medicare incentive payment amounts are based on 75 percent of the estimated allowed charges for covered professional services furnished by the eligible professional during the payment year, as determined by claims submitted no later than two months after the end of the payment year.

- CHIP is indistinguishable from Medicaid: Oregon has streamlined State health care programs to be known publicly as Oregon Health Plan (OHP) rather than by the funding source or program name. In addition, Oregon has been recognized as a national leader in enrolling children for health care by expanding health care coverage in the past two years to 70,000 children under the Healthy Kids program funded by CHIP. To qualify for a Medicaid EHR incentive payment, eligible professionals not practicing predominately in an FQHC or RHC must have 30% (20% for pediatricians) Medicaid patient volume which excludes CHIP. Providers have no way of knowing which children they see under the Oregon Health Plan are covered by Medicaid and which are covered by CHIP, and will over-calculate their patient volume. Oregon's incentive program staff will need to work directly with some applicants to ensure that they meet the patient volume thresholds. See Section C.6 for Oregon's approach to this issue.
- Balancing "the need to get it done" with "the need to get it done right," including meeting the needs of CCOs and Medicaid providers related to clinical quality metrics and data aggregation, privacy and security issues, and launching notifications services.

SECTION E: THE STATE’S HIT ROADMAP

- 1. PROVIDE CMS WITH A GRAPHICAL AS WELL AS NARRATIVE PATHWAY THAT CLEARLY SHOWS WHERE THE SMA IS STARTING FROM (AS-IS) TODAY, WHERE IT EXPECTS TO BE FIVE YEARS FROM NOW (TO-BE), AND HOW IT PLANS TO GET THERE.**

A consistent request of Oregon stakeholders was that the State provide clarity and information on the State strategy and roadmap, federal requirements and standards as they evolve, and evolving technology and promising approaches (e.g., mobile devices). The State embraced a structured stakeholder engagement process that has resulted in phased pathway for the State of Oregon. See roadmap below:



As addressed more fully in the Business Framework Plan provided in Appendix A, the State, health plans, Medicaid Coordinated Care Organizations (CCOs), health systems, providers and other stakeholders are seeking to transform the health care system to improve health, provide better care and lower costs. This health system transformation is multifaceted, relying on new models of care coordination, wellness, incentives and alternative payment models. These key features of transformation are dependent on and demand improvements in the exchange of actionable health information, which is dependent on sufficient health information technology

(HIT), which is further dependent on adequate technical infrastructure, appropriate policies and legal authority, sufficient and sustainable financing, and governance of the exchange of information as well as the health information exchange (HIE) technology.

Technology roadmap

- “As-Is”: current services include CareAccord® Direct secure messaging;
- “Future (To-Be) State”: The future state of HIT/HIE in Oregon relies on the following interdependent elements:
 - Local HIEs, health systems, and other entities provide HIT and HIE services to some providers;
 - Statewide Direct secure messaging provides a foundation for sharing information across organizations and differing technologies;
 - CareAccord® provides common services as baseline HIE capabilities to those without access to local or health system HIEs, specifically offering Direct secure messaging capabilities and access to the enabling infrastructure;
 - Statewide enabling infrastructure ties local efforts together, enabling exchange and HIT functions (such as identifying providers or locating patient records) across local HIEs, health systems and other entities; and
 - State-level aggregation of key clinical quality data for the Medicaid program, develop benchmarks and other quality improvement reporting, and calculate clinical quality metrics for paying quality incentives to CCOs and Medicaid EHR incentive payments to providers

Governance, policy, and operations roadmap

- “As-Is”: currently OHA operates State-level HIE services (i.e., CareAccord® Direct secure messaging), and staffs stakeholder committees including the Health Information Technology Oversight Council (HITOC).
- “Future (To-Be) State”: The future state of HIT/HIE in Oregon relies on the following interdependent elements:
 - The State will provide oversight, transparency, policy-setting, and accountability over statewide HIT/HIE services, statewide direction, ensuring compliance with federal requirements (Medicaid, HIPAA, etc.), and meaningful ongoing engagement of stakeholders.
 - An external HIT designated entity will operate statewide services.
 - The State will establish an HIT/HIE compatibility program. Any entities seeking to participate in State enabling infrastructure services would need to meet program expectations.

Finance roadmap

- “As-Is”: currently OHA funding for state-level HIE services and efforts (e.g., CareAccord® Direct secure messaging, planning for Phase 1.5 services, etc.) come from ONC State HIE Cooperative Agreement funding, State general funds, MMIS/HITECH Act IAPD and MMIS Operations APD funding.

- *“Future (To-Be) State”*: The future state of HIT/HIE in Oregon relies on the following interdependent elements:
 - Overall financial sustainability relies on the development and implementation of a broad-based financing model. OHA will consider seeking fee-setting and collecting authority for HIT/HIE services along with Medicaid funding.
 - CareAccord® (statewide Direct secure messaging): MMIS dollars will support ongoing Medicaid-related costs with required State match. Any non-Medicaid costs will be covered by fees and/or contributions from non-CMS sources.
 - Emergency Department Information Exchange (EDIE): OHA partnered with the Oregon Health Leadership Council (OHLHC) to make a one-time, non-Medicaid investment in the privately-led EDIE initiative. All 59 of Oregon’s hospitals have agreed to implement EDIE by November 2014, and will receive funding for the first year of the subscription service.
 - Phase 1.5 Near-Term Services (see Section A.9) supported through MMIS and HITECH Act CMS funding for the appropriate Medicaid-related costs (IAPDUs to be submitted in early 2014). OHA is currently seeking other partners to cover fair share financing to extend services beyond Medicaid.
 - Phase 2.0 Longer Term Services (see Section B.2) will be supported through MMIS and HITECH Act CMS funding for the appropriate Medicaid-related costs, and non-Medicaid costs will be covered by fees and contributions from other partners (e.g., cost allocation to other OHA programs.)

Timeline for Phase 1.5 and related efforts

OHA will direct Phase 1.5 implementation efforts with input and advice from the CCOs and key stakeholders. OHA anticipates development and implementation of Phase 1.5 and related efforts along the following timeline:

Dates	Efforts
Fall 2013 – July 2015	Ongoing OHA efforts to support and leverage Direct secure messaging, particularly for the state Medicaid program and Medicaid CCOs and providers <ul style="list-style-type: none"> • Continue CareAccord® Direct secure messaging services for targeted providers • Facilitate and monitor connections between Direct secure messaging service providers • Participation in Trust Communities to ensure connection between Direct secure messaging service providers
Sept. – Nov. 2013	Establish health information technical advisory group (HITAG) for Phase 1.5; HITAG and OHA to identify requirements for contracting and develop implementation plan to specify phasing, timelines and scope
Winter 2013 – spring 2014	<ul style="list-style-type: none"> • OHA to develop requirements for Phase 1.5 RFP/contracts with HITAG input • OHA to submit IAPDs to seek federal financial participation for Phase 1.5

Dates	Efforts
2014	As certification standards for EHRs require use of Direct, support providers in achieving Meaningful Use, fitting Direct into workflows, and leveraging Direct for improved care coordination across care settings
2014	Contracting process(es) for Phase 1.5 services
Summer 2014	Initial services contracted and development begins for Phase 1.5 elements
2014	Technical assistance supports Medicaid providers to achieve Meaningful Use, receive incentive payments, participate in Direct secure messaging and be ready to submit data to clinical quality metrics registry
Winter 2014	Using EDIE, emergency department doctors across Oregon have critical patient information on high utilizers
Spring 2015	Initial Phase 1.5 services operational
July 2015	Achieve statewide Direct secure messaging: Direct is in use to provide an on-ramp for connecting all members of the care team electronically and to facilitate economical exchange of clinical information <ul style="list-style-type: none"> • HISPS in Oregon are connected • care team members have an option to use Direct secure messaging, whether integrated into an EHR or accessed through a web portal
2015	Unnecessary utilization of emergency department is reduced
2015	Statewide resources (provider directory, notifications, patient attribution service) support local exchange and analytics efforts
2015	Clinical quality metrics registry (CQMR) is operational and used to produce CCO metrics and beginning to collect CQMs for Medicaid EHR Incentives
2015	Because of technical assistance support, clinical quality metrics registry data is increasingly valid and credible
2016	Clinical quality metrics registry includes dashboards and benchmarks

Phase 2.0

In 2015 and beyond, Oregon’s statewide HIT/HIE efforts will be expanded to provide or support robust, interoperable health information exchange that supports both data “push” as well as data “query” (following the evolution of national standards) and more robust data aggregation.

The timeline for Phase 2.0 is as follows:

Dates	Efforts
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2014 – 2015	Phase 2.0 development and implementation planning, including HITOC policy work/oversight
2015	Phase 2.0 legislation possible and implementation begins
2015	Sustainable funding sources in place

2. WHAT ARE THE SMA’S EXPECTATIONS RE PROVIDER EHR TECHNOLOGY ADOPTION OVER TIME? ANNUAL BENCHMARKS BY PROVIDER TYPE?

Expectations of EHR adoption

In late 2013, Oregon developed the following projections for participation in the Medicaid EHR Incentive Program. These numbers are estimates created only for long-term planning purposes, based on current experience. Oregon will be updating the annual benchmarks in a separate SMHP update to be submitted later this quarter.

Medicaid EHR Incentive Projections for FFY2014-2015

FFY	FFY14 Total	FFY15 Total	Total FFY14-15
EP at full rate	2339	2176	4515
Pediatrician	121	114	235
EP Totals	2460	2290	4750
Hospitals	105	0	105

AIU	FFY14 AIU	FFY15 AIU	Total AIU
EP at full rate	932	798	1730
Pediatrician	48	42	90
EP Totals	980	840	1820
Hospitals	8	0	8

MU	FFY14 MU	FFY15 MU	Total MU
EP at full rate	1407	1378	2785
Pediatrician	73	72	145
EP Totals	1480	1450	2930
Hospitals	97	0	97

Eligible hospital incentive payment analysis assumptions

In developing new projections for eligible hospitals, OHA made the following assumptions about the 58 Oregon hospitals that are expected to receive Medicaid incentives:

- 39 hospitals will finish receiving payments in FFY 2014 or FFY 2015. That includes hospitals that received their initial payment in
 - 2011 but did not participate in 2012 and are assumed to participate in 2013 and 2014 (20 hospitals), or
 - 2012 and are assumed to participate in 2013 and 2014 (19 hospitals).

- The nine (9) hospitals that did not receive a payment in 2011 or 2012 will begin receiving payments for AIU in 2013 and participate in consecutive years through 2015. Their third payment, totaling \$592,725, is not included in these estimates, as they cannot apply for that payment until FFY 2016.
- 10 hospitals that began participation in 2011 and received another payment in 2012 will receive their final payment for FFY 2013 in FFY 2014;
- For hospitals expected to adopt, implement or upgrade in year one (2013), estimates from the Witter and Associates (see Appendix D) were used for to estimate payments.

Hospital Estimates Medicaid EHR Incentive Projections for FFY2014-2015

Total Eligible Hospitals (EH) that Attested	# of EHs	Total
Did not apply in 2011 or 2012	9	\$4,960,025
AIU in 2012 and anticipated to attest to MU in 2013	15	\$8,157,660
MU in 2011, but not in 2012	3	\$772,178
MU in 2011 and 2012	3	\$803,523
AIU in 2011, but did not apply attest to MU in 2012	17	\$9,478,774
AIU in 2011 and MU in 2012	7	\$1,223,497
MU, not AIU, in 1st year in 2012	4	\$1,563,146
TOTALS	58	\$26,958,804

Eligible professionals incentive payment analysis assumptions

- Estimates for EPs assume 1500 new providers will apply in program year 2013 and 500 new providers in 2014 and 2015. We chose to increase this percentage from earlier estimates based on the more flexible Stage 2 rule for Medicaid patient volume definitions and incentives for Meaningful Use under Oregon’s Medicaid Coordinated Care Organizations (CCOs). We also learned one of our largest provider organizations identified an additional 850+ providers who are eligible for and expected to attest in program year 2013.
- Pediatricians paid at 2/3 are estimated to continue to represent 5% of all EPs.
- A maximum of roughly 700 applications will processed per quarter by the incentive program team.
- 100% of EPs will participate in consecutive years and achieve MU in their 2nd year.
- EP projections are based on current applications submitted to the program for program years 2011, 2012, and 2013.

Other notes on EHR adoption benchmarks

Oregon’s Medicaid 1115 waiver includes financial incentives (“quality pool”) related to 17 metrics starting in 2013, including one metric for Meaningful Use of EHRs and three for Meaningful Use clinical quality measures (CQMs). Among the quality pool measures for CCOs,

Oregon's Metrics and Scoring Committee³¹ developed a benchmark for EHR adoption. This measure determines the providers in a CCO's service area that qualified for incentive payments under the Medicaid, Medicare, or Medicare Advantage EHR Incentive Program for adoption or meaningful use of certified EHR technology, compared to an estimate of the providers in the CCO's network who were eligible to receive these payments. The benchmark is 49.2 percent, and is based on the federal assumed rates for non-hospital based EHR adoption and meaningful use by 2014.³²

CCOs also report on three clinical quality measures: controlling high blood pressure (NQF 0018); screening for clinical depression and follow up plan; and diabetes control - HbA1c poor control (NQF 0059). Because each of these measures also is a Meaningful Use measure, use of these metrics further encourages meaningful use of EHRs for quality reporting.

In addition, Oregon's Patient-Centered Primary Care Home (PCPCH, Oregon's medical home model) standards align with State HIT objectives, including Meaningful Use measures and health information exchange. PCPCH Program has adopted EHR-related recognition criteria, including measures for:³³

- Ensuring that clinical advice provided by telephone is documented in the EHR within 24 hours of the call (Measure 1.C.1);
- Providing patients with an electronic copy of their health information upon request, using a method that satisfies either Stage 1 or Stage 2 Meaningful Use measures (Measure 1.E.3);
- Sending patients reminders for preventive/follow-up care using a methods that satisfies either Stage 1 or Stage 2 Meaningful Use measures (Measure 3.E.3);
- Sharing clinical information electronically in real time with other providers and care entities (Measure 4.D.3);
- Performing medication reconciliation for patients in transition of care, using a method that satisfies either Stage 1 or Stage 2 Meaningful Use measures (Measure 4.G.3);
- Being Meaningful Users of certified EHRs³⁴ (Measure 5.B.3).

Because CCOs integrate physical, behavioral and oral health care, metrics for CCOs reach all of these provider types and encourage EHR adoption even among Medicaid providers who are not eligible for incentive payments.

3. DESCRIBE THE ANNUAL BENCHMARKS FOR EACH OF THE SMA'S GOALS THAT WILL SERVE AS CLEARLY MEASURABLE INDICATORS OF PROGRESS ALONG THIS SCENARIO.

³¹ <http://www.oregon.gov/oha/Pages/metrix.aspx>

³² [http://www.oregon.gov/oha/CCODData/Electronic%20Health%20Record%20\(EHR\)%20Adoption%20-%20FINAL.pdf](http://www.oregon.gov/oha/CCODData/Electronic%20Health%20Record%20(EHR)%20Adoption%20-%20FINAL.pdf)

³³ <http://www.oregon.gov/oha/OHPR/Documents/2014%20PCPCH%20Recognition%20Criteria%20TA%20Guide%20FINAL%2010.4.13.pdf>

³⁴ This measure tracks Meaningful Use among non-EPs as well as EPs. If the providers at a clinic are ineligible for EHR incentives, the clinic can satisfy the measure by using a CEHRT and producing a Meaningful Use scorecard.

Although the following goals target all providers, OHA's efforts focus largely on Medicaid providers and benchmarks to CMS will focus on Medicaid providers and CCOs to the extent feasible.

Goal 1: Ensure all providers can access meaningful, reliable, actionable patient information shared across organizations and differing technologies through community, organizational and/or statewide health information exchange. To do so, State efforts will:

- **Support and facilitate provider adoption and Meaningful Use of certified EHRs, and support the goal that all providers have a means to use key patient information, including behavioral health, dental and long term care.**
- **Support the protection, privacy and security of shared patient information.**

Objective 1: Increase access to patient information shared across organizations and differing technologies, to achieve statewide interoperable, secure exchange of patient information:

- Objective 1.1: Increase number of Medicaid eligible providers adopting and meaningfully using certified EHR technology.
 - *Benchmark:* Medicaid EP/EH adoption/MU rates (incentive program data)
 - *Benchmark:* Extent of technical assistance to Medicaid providers (TA program data, expected by end of FFY 2014)
- Objective 1.2: Increase providers' ability to coordinate care across practice settings, (including information exchange between providers eligible for EHR incentives and those not eligible such as long term care providers) by increasing adoption of Direct secure messaging and access to other health information technologies by behavioral health, dental and long term care providers.
 - *Benchmark:* Medicaid EP/EH adoption/MU rates and CareAccord subscriber rates (to assess providers not eligible for incentives) by organization type, including data on Behavioral Health, Dental, and Long Term Care providers (Medicaid incentive program data, CareAccord data)
- Objective 1.3: Increase adoption and use of Direct secure messaging that is interoperable across EHR/HISP vendors.
 - *Benchmark:* Utilization data for Medicaid prior authorization requests and appeals to DMAP via Direct secure messaging (DMAP Prior Authorization and Appeals program data)
 - *Benchmark:* Number of Oregon's community HIEs connected to CareAccord for interoperable Direct secure messaging (CareAccord program data)
- Objective 1.4: Increase use of CareAccord Direct secure messaging services targeted to Medicaid programs, providers, and other members of health care teams, particularly those without access to EHRs and/or HISP services.
 - *Benchmark:* Utilization data for Medicaid prior authorization requests and appeals to DMAP via Direct secure messaging (DMAP Prior Authorization and Appeals program data)
 - *Benchmark:* Analysis of CareAccord subscriber data and Medicaid affiliation (CareAccord data)

- **Objective 1.5:** Improve and accelerate sharing of patient information across community and organizational HIT efforts.
 - *Benchmark:* EDIE participation data. (EDIE program data – expected by end of 2014)
 - *Benchmark:* State hospital notifications program utilization data (Notifications program data*)
 - *Benchmark:* State provider information repository services program utilization data: (Provider information services program data*)
 - *Benchmark:* State patient/provider affiliation services program utilization data. (Patient/provider affiliation services program data*)
 - *Benchmark:* Number of Oregon’s community HIEs connected to CareAccord for interoperable Direct secure messaging (CareAccord program data)

**Benchmark data will be phased in as Phase 1.5 services become operational*

Goal 2: Support CCOs, health systems, health plans, and providers in using aggregated data for quality improvement, population management, and to incent value and health outcomes.

Objective 2: Improve use of aggregated clinical data for Medicaid and other State programs, CCOs, health plans, and other health system partners.

- *Benchmark:* Number of Medicaid EPs receiving incentive payments who submitted individual-level CQM data to Oregon’s clinical quality metrics registry (either directly, or through a data intermediary). (Clinical quality metrics registry program data*)
- *Benchmark:* Number of Medicaid providers submitting individual-level CQM data for the CCO CQMs to Oregon’s clinical quality metrics registry (either directly, or through a data intermediary). (Clinical quality metrics registry program data*)
- **Objective 2.2:** Improve ability of Medicaid and other State programs, CCOs, health plans and other health system partners to aggregate data for policy, analytic, quality improvement, and operational purposes.
 - *Benchmark:* State provider information repository services program utilization data: (Provider information services program data*)
 - *Benchmark:* State patient/provider affiliation services program utilization data. (Patient/provider affiliation services program data*)

**Benchmark data will be phased in as Phase 1.5 services become operational.*

Goal 3: Facilitate individual and family or caregiver engagement through access to and interaction with, their health information.

Objective 3: Improve individual/family access to their meaningful health information

- *Benchmark:* Number of Oregon EPs and EHs achieving Meaningful Use Stage 2 (incentive program data).

Benchmarks and baselines and reporting:

OHA will report annually to CMS on benchmarks outlined above as part of end of FFY program reporting.

- CareAccord and Incentive program data are currently available. Metrics will be compared to prior year performance. Benchmarks and projections for EHR incentive program rates are discussed in Section E.2. For CareAccord program data, see Section A.7 for December 2013 utilization rates, which will form the baseline for comparison purposes in calculating annual benchmark data moving forward. OHA will report on utilization rates for Medicaid providers and other Medicaid-related entities (such as CCOs).
- Utilization data for Medicaid prior authorization requests and appeals to DMAP via Direct secure messaging. Metrics will be compared to prior year performance, with a baseline of zero Medicaid prior authorization requests and appeals to DMAP via Direct secure messaging at the end of FFY 2013, which is the baseline year.
- Because Phase 1.5 services are not yet implemented, benchmarks will be defined and baselines established as these services become operational (indicated with * above). Increases or improvement metrics will be compared to prior year performance, with most Phase 1.5 metrics starting with a baseline of zero utilization at end of FFY 2013.

Oversight Activities

Oregon adapts its oversight strategy to accommodate requirements as they evolve and will do so to accommodate Meaningful Use Stage 3 when it becomes a reality. A major focus of the current activities is:

1. educating and engaging EP types and EHs so they understand and correctly input the necessary information as the State transitions from attestation to quality measurement reporting;
2. adapting the audit strategies to accommodate the changes of Meaningful Use Stage 2; and
3. doing the necessary policy, procedure and internal staff education to assure implementation aligns with state and federal policies.

In the broader HIT/HIE scope, the State will provide oversight, transparency, policy-setting, and accountability over statewide HIT/HIE services and will seek to contract with an external HIT designated entity to operate statewide services. To ensure interoperability and security of information exchanged through statewide services and protect privacy, OHA will establish a new HIT/HIE compatibility program (see Section B.4). Any entities seeking to participate in State enabling infrastructure services would need to meet HIT/HIE compatibility program expectations.

CONCLUSION

This document lays out the State's plans for expeditiously and efficiently implementing the Medicaid EHR Incentive Program to maximize and expedite incentives to Oregon providers. Oregon will submit annual SMHP and I-APD updates, and other updates as needed. Further, Oregon anticipates providing SMHP and I-APD updates to CMS before the end of the second quarter in Federal Fiscal Year 2014.

Oregon is poised to continue its implementation work, and looks forward to working with its stakeholders and CMS to ensure that Oregon's strategies to facilitate adoption and Meaningful Use of electronic health records and HIE are successful. These strategies will ultimately help Oregon achieve the goals of federal and state health system transformation: improving health outcomes, increasing quality, reliability, and availability of care for all Oregonians, and lowering or containing costs of care to make it affordable to all.

Environmental Scan

Section Overview

- Oregon's health care providers rank well above the national average for EHR adoption. 65.5% of office-based physicians are in a practice where an EHR is present. As of 2009, 47 of Oregon's 58 acute care hospitals had an EHR or had anticipated implementing one in 2010.
- All but nine Oregon hospitals are expected to meet eligibility requirements for Medicaid incentive payments. For eligible professionals (EPs) in Oregon, preliminary estimates show that more than half of pediatricians are expected to meet requirements, as are nearly all physicians in federally qualified health centers (FQHCs) and rural health clinics, and between 5% and 10% of other physicians (non-pediatricians, not in FQHCs).
- Oregon is actively building broadband networks around the state with the assistance of federal funds. Despite its large rural areas, Oregon ranks eighth among states on household access to a broadband connection.
- Oregon's health information exchange strategic and operational plans were approved by ONC in December 2010. The state has a number of health information exchange organizations (HIOs) in the operational or soon-to-be operational stage, and eight health systems offer some stage of health information exchange (HIE) services.
- Oregon's planning is well integrated with other health reform initiatives such as health information exchange, the planning for an Oregon health insurance exchange, medical home initiatives, Oregon's CHIPRA grant and other key efforts being conducted to improve the health of Oregonians.
- Oregon has updated its Medicaid Management Information System (MMIS), processing claims faster and more efficiently. The MMIS will play an important role, along with the 24-hour access Provider Web Portal, for the Medicaid EHR Incentive Program. Oregon's MMIS is currently undergoing certification.

1. Overview of EHR adoption

Oregon has invested in ongoing research on health information technology adoption and implementation rates among providers and hospitals. Oregon's Office for Oregon Health Policy and Research conducted a health information technology inventory in February 2010.¹ The inventory included results from various sources, including four surveys:

- Oregon 2009 Ambulatory EHR Survey, which was sent in February 2009 to 2,273 ambulatory clinics and physician practices (respondents included 1,168 practices and clinics and 7,845 clinicians, representing a 57.7% overall response rate from practices);²
- Oregon HIT Assessment, 2009: Hospital and Health System Survey;
- Oregon HIT Assessment, 2009: Independent Physician Association Survey; and
- Oregon HIT Assessment, 2009: Health Plan Survey.

¹ Office for Oregon Health Policy and Research, Oregon's HIT Environmental Assessment, February, 2010. Prepared by David M. Witter, Jr., Witter & Associates. Available at:

http://www.oregon.gov/OHPPR/HITOC/docs/Oregon_HIT_EnvironmentAssessment20100209.pdf.

² Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009, p. 8. Prepared by David M. Witter, Jr., Witter & Associates. Available at: <http://www.oregon.gov/OHPPR/HITOC/docs/OR2009EHRSurvey.pdf>

The 2009 Ambulatory EHR Survey was intended to measure adoption rates across practices (regardless of payer type) to provide a picture of how access to health IT was progressing for all Oregonians, and so did not focus specifically on Medicaid providers.

2. Provider adoption of EHRs

Oregon health care providers rank well above the national average for electronic health record adoption. According to 2009 Ambulatory EHR Survey, 65.5% of Oregon office-based physicians are in a practice where an EHR is present, compared with 43.9% nationally; 32.2% of Oregon physicians use a fully functional EHR, compared with 6.3% nationally.

Reasons for providers' EHR adoption

2009 Ambulatory EHR Survey respondents identified the perceived benefits of EHR adoption as improving access and tracking of patient information, eliminating the potential for lost patient charts, efficiency/reduce costs for transcription and filing/records management, record legibility, e-prescribing and medication lists, and better patient care/safety and coordination of care.³

The most cited implementation concerns include the expense, loss of productivity, ongoing costs and expense of purchase. Additional concerns include inadequate return on investment, need to customize EHRs, staff training, interfacing data with other systems and physician resistance to change.

Factors associated with high and low rates of adoption

Factors associated with high EHR adoption rates include the size of the health system or practice. Large health systems and practices tend to have higher adoption rates. Kaiser and Oregon Health & Science University have 100% adoption, health system-operated/affiliated practices or clinics have 70%, federally qualified health centers have 60% and community hospitals have 57%. Practices with larger numbers of clinicians range from a 50% EHR adoption rate (for practices with five to nine clinicians) to 79% adoption rate (for practices with 50 or more clinicians). Practices with more than one location have a range of 40% (for five locations) to 69% (for five or more locations).⁴

Factors associated with low EHR adoption rates include being a solo clinician practice (26%) or a practice with two to four clinicians (40%). Freestanding ambulatory surgery centers tend to have lower adoption rates (22%), as do public/tribal/institution-based clinics (public health departments, school-based clinics, tribal clinics and college health centers) that are not federally qualified health centers (FQHCs) (23%).

Survey definitions and methods

The 2009 Ambulatory EHR survey defines an Electronic Practice Management (EPM) System as including patient scheduling, registration, eligibility, coverage contracts, billing, electronic claims submission, claims tracking, accounts receivable, workflow management tools and reports. The survey defines three categories of EHR system, "any EHR", "basic EHR", and "fully functioning EHR" based on definitions in a widely cited paper, *DesRoches et al* (2008).

The category of "any EHR" includes any type of EHR self-declared by a survey respondent, including self-developed systems. The category of "basic EHR" system includes all of the following functional components: patient demographics, patient problem lists, electronic medication lists, clinical notes, order entry management of prescriptions, and viewing capability of laboratory and imaging results (reports). The category of "fully functional EHR" system includes the basic system functionalities of clinical notes of the medical history and follow-up, ordering of laboratory and radiology tests, electronic transmission of prescriptions and orders, and electronic return of images. Fully functional also includes clinical decision support with warnings of drug interactions or contraindications, highlighting out-of-range test levels and reminders regarding guideline-based intervention screening.

The survey defines "clinicians" as physicians (MDs and DOs), physician assistants (PAs), and nurse practitioners (NPs). Although the current data do not support an analysis of the distinction between Medicaid providers and others, EHR adoption rates among different provider practice types are discussed in detail below.

³ 2009 Ambulatory EHR Survey, p. 3.

⁴ 2009 Ambulatory EHR Survey, p. 2.

Adoption by setting/provider type

The 2009 Ambulatory EHR Survey provided information about EHR systems; it measured responses from provider locations rather than providers themselves. This approach takes into account the possibility that providers work in multiple locations. The expected result of this approach is a greater survey response rate per system and reduced duplicity of reporting among providers. The data gathered through this approach does not reflect specific provider types.

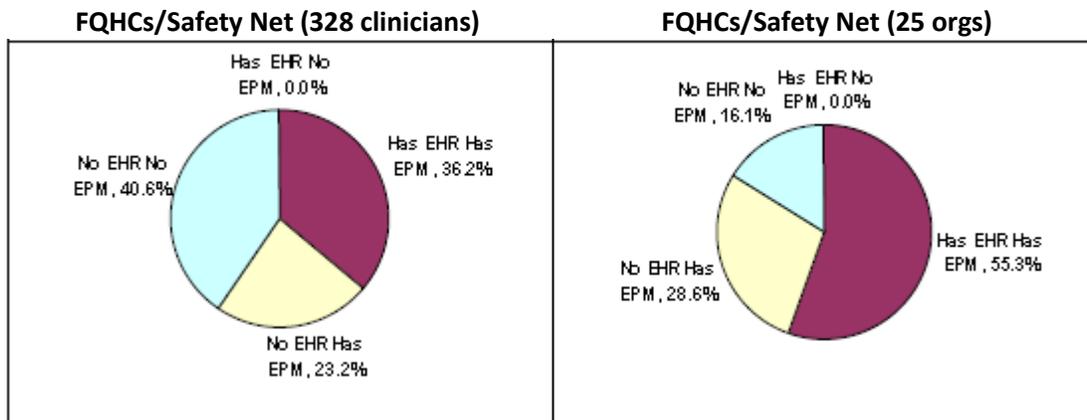
The highest rates of clinician adoption are for practices/clinics operated by health systems (95.8%) and Kaiser and OHSU (100%). The lowest clinician access to EHRs occurs in ambulatory care centers (8.6% of 535 ambulatory care center clinicians), clinician name practices (25.1% of 426 clinicians) and public/other clinics (37.6% of the 189 clinicians).⁵

The highest rate of adoption related to specialists is for multi-specialty practices (90.1%) and mixed primary care clinics (69.8%). Multi-specialty practices and mixed primary care practices represent 54.6% of the surveyed clinicians. The lowest adoption rates are for specialty categories of ophthalmology/optometry (29.0%) and surgery and surgical specialties (24.9%).⁶

Adoption for safety net providers

EHR adoption rates among Oregon’s safety net providers are bolstered by the work of a non-profit Health Center Controlled Network, OCHIN. OCHIN has also received the ONC award to become Oregon’s Regional Extension Center (REC), and has formed a division, O-HITEC, to provide REC services in Oregon. The function of O-HITEC is discussed in greater detail on page 21.

Among responding safety net organizations, including FQHCs and rural health centers (RHCs), 60% have both EHR and electronic practice management (EPM), 36% have no EHR but do have EPM, and 4% have no EHR and no EPM. Among responding clinicians, 65.5% have both EHR and EPM, 33.5% have no EHR but do have EPM, and 0.9% have no EHR and no EPM.⁷ However, by 2011, safety net respondents forecasted that 88% of the clinics would use an EHR serving 94% of the clinicians in FQHCs.



Source: Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009

⁵ 2009 Ambulatory EHR Survey, p. 14.
⁶ 2009 Ambulatory EHR Survey, p. 20.
⁷ 2009 Ambulatory EHR Survey, p. 32.

FQHCs, FQHC lookalikes and HIT grants

Oregon's 27 FQHCs and 2 FQHC look-alikes provide services in 153 sites throughout the state. Fifteen of the FQHCs are OCHIN members. Recently, Oregon's FQHCs have received some federal government and non-profit HIT grant funding.

Seventeen FQHCs in Oregon were awarded Capital Improvement Program (CIP) grants by the federal Health Resources and Services Agency (HRSA). These grants were made available via the American Recovery and Reinvestment Act of 2009 and provided funds to support construction, repair, renovation, and equipment purchases. Equipment purchases permitted include HIT systems and EHR-related enhancements for Community Health Centers. Total CIP funding to Oregon FQHCs was \$14.3 million.⁸

In August 2009, United Way awarded the Coalition of Community Clinics a Project Innovation Grant in the amount of \$36,000. This coalition includes thirteen FQHC clinics in the Portland Metro area. The grant has three primary deliverables, one of which is the creation of an information technology plan for each of the eight community-sponsored clinics. Currently these clinics are working with OCHIN to develop a plan for adoption of an EPIC EHR system in most clinics. EPM adoption is expected in one to two years, while full EHR adoption may take three to five years.⁹

Rural health clinics

Oregon has 60 RHCs that operate throughout the state Oregon. Rural clinics have a broad range of capacity and demand for health IT. Of the 46 RHCs that responded to a 2007 survey, 63% report that they do not use or have electronic medical records.¹⁰ Thirty of the 46 RHC respondents were without EHRs, 11 report planning to implement an EHR in the next year, 16 report being unable to implement an EHR due to the prohibitive monetary cost, and nine list both prohibitive cost and time required as reasons for being unable to implement an EHR.

Safety net clinics supported by OCHIN and HRSA funding

EHR adoption rates by FQHCs and Community Based Health Centers (CBHCs) have been accelerated by OCHIN. Fifteen of the 29 FQHCs/FQHC look-alikes are OCHIN members. OCHIN has 18 members in Oregon, and several in four other states; its members operate clinics in more than 200 locations. OCHIN provides a comprehensive suite of products including practice management and EHR (Epic) services, panel and population management tools to member organizations.

As an Organized Health Care Arrangement (OHCA) under HIPAA with a single record per patient, OCHIN functions as an HIO among its member organizations. The OCHIN master patient index contains information on more than 400,000 Oregonians and 600,000 lives across California, Oregon and Washington. OCHIN also operates SafetyNetWest, a practice-based research network that solicits proposals and coordinates research projects involving safety-net populations.¹¹

⁸ HRSA websites, accessed Jan. 28, 2011, including: Capital Improvement Program Announcement Number: HRSA-09-244 Date: May 1, 2009 (<http://bphc.hrsa.gov/recovery/cip/capitalimprovementguidance.pdf>), Oregon FQHC grantees and awards amounts from: <http://granteefind.hrsa.gov/> and matched to two customizable data warehouse reports accessed via <http://datawarehouse.hrsa.gov/customizereports.aspx>.

⁹ Conversation with Tracy Grotto, former executive director of the Coalition of Community Health Clinics, Jan. 4, 2011.

¹⁰ Oregon Health & Science University Office of Rural Health, Oregon Federally Certified Rural Health Clinics, 2008 Report, p. 39. This office recently completed a new survey of RHCs, and results are expected by spring 2011.

¹¹ Oregon Health Authority and the Health Information Technology Oversight Council (HITOC), Health Information Exchange: A Strategic Plan for Oregon, August 23, 2010, p. 73. Available at: <http://www.oregon.gov/OHPPR/HITOC/Documents/SandOpPlans201008/HIEStrategicPlanOR.pdf>.

In 2007, OCHIN received three grants from the federal Health Resources and Services Administration (HRSA) totaling nearly \$3 million to support implementation of EHRs at health centers and in networks that link multiple health center grantees, and to help health center networks implement HIT other than electronic health records, such as electronic prescribing, physician order entry, personal health records, community health records, health information exchanges, and creating interoperability.¹²

County and local health clinics

Oregon has 34 local public health departments (LHDs) that serve Oregon's 36 counties. A May 2010 survey found that, of 32 responding health departments, only four reported having an EHR system in active use. Among the 32 respondents, 28 reported actively using an EHR, an EPM, or both. Conversely, only four of the 32 local health departments are not using either an EHR or EPM.¹³

Survey responses reveal that Oregon's LHDs provide a range of primary and preventive care services.

- Nursing services and case management are both offered at 30 out of 32 responding LHDs.
- Nutrition services are offered at 12 LHDs.
- Mental health services are offered at 13 LHDs.
- Primary care/physician services are offered at 12 LHDs.
- Substance abuse treatment services are offered at 11 LHDs.
- Social work services are offered at 9 LHDs.
- Six LHDs indicate that they offer other services, including such services as: immunizations, STI screening and treatment, HIV testing, TB treatment, refugee screening, home visit/community nursing, school based health centers, school nursing, dental services, developmental disabilities services, corrections health, pharmacy, prenatal care, and family planning.

Although 12 health departments indicate providing primary care/physician services, three of these reported having no EHR or EPM.

In addition to providing clinical services, county health departments play a critical role in public health surveillance. Approximately 80% of communicable disease reporting occurs electronically to local health departments from 12 clinical laboratories and the Oregon State Public Health Laboratory. These reports flow into the recently upgraded Oregon Public Health Epi-User Systems (Orpheus) and are the basis of reporting to the Centers for Disease Control and Prevention (CDC).¹⁴ See page 23-25 for more information about Oregon's public health surveillance systems.

EHR types and products

Across all practice types, respondents identified the use of 83 different vendors/products, with 76 vendors/products identified for independent clinician organizations.¹⁵ In addition, 11 organizations serving 23 clinicians indicated that they were using self-developed EHR systems.¹⁶

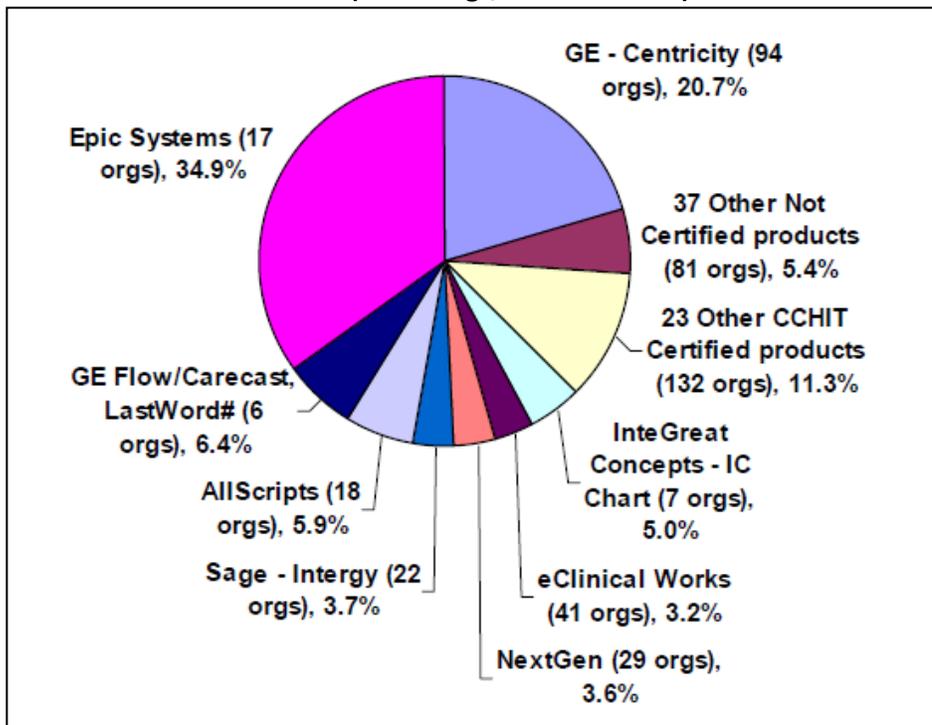
¹² HRSA press release, "HRSA Awards \$31.4 Million to Expand Use of Health Information Technology at Health Centers, August 27, 2007.

¹³ Office for Oregon Health Policy and Research, Public Health and Health Information Exchange: A Survey of Oregon's Local Health Departments. September 2010. Available at www.oregon.gov/OHPPR/HITOC/index.shtml, pg. 11.

¹⁴ Oregon HIE Strategic Plan, p. 14.

¹⁵ Clinician organizations are practices and clinics operated by independent physician practitioners or groups that are not under the ownership or auspices of hospitals or health systems nor operated by a FQHC, safety net or public clinic.

**EHR Market Share of Clinicians – All Organizations
(n=447 orgs, 5139 clinicians)**



Source: Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009

Eight vendors/products account for 83.3% of the clinicians served by EHR products. The largest market share in terms of clinicians served are EpicCare (17 organizations with 34.9% of clinicians) and GE-Centricity (94 organizations with 20.7% of clinicians). Other GE EHR products (Flowcast, CareCast and LastWord) related to the acquisition of the IDX company several years ago involve 6.4% of clinicians at six organizations. These other GE EHR products are not certified by the Certification Commission for Health Information Technology (CCHIT) and several of the organizations are implementing replacement EHR systems that are CCHIT-certified.¹⁷ Smaller market shares involve twenty-three vendors/products that are CCHIT-certified are serving 132 organization representing 11.3% of clinicians covered by the survey. Thirty-seven vendors/products that are **not** CCHIT-certified are serving 81 organizations representing 5.4% of clinicians covered by the survey. Many of these non-certified products are focused on specific medical specialties.^{18,19}

The eight vendors/products account for 74.7% of the clinician organizations served by EHR products. The largest market share in terms of clinician organizations and clinicians use is GE Centricity (74 organizations and 21.3% of clinicians). The next largest vendors in terms of practice organizations served are eClinicalWorks (37 clinician

¹⁶ 2009 Ambulatory EHR Survey, p. 35.

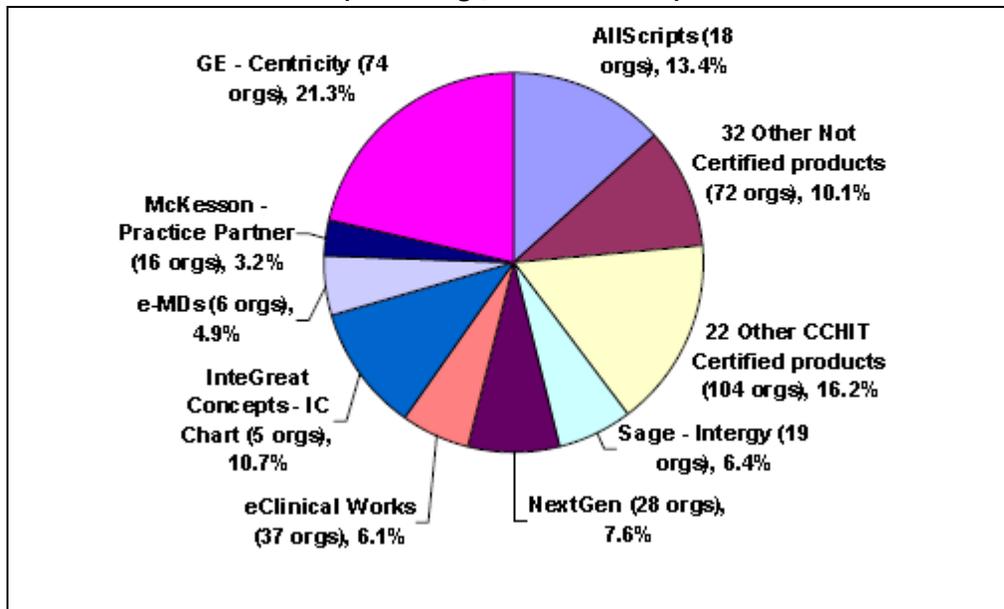
¹⁷ This refers to the CCHIT certification process, which preceded the current federal effort to certify electronic medical records systems for compliance with meaningful use requirements.

¹⁸ 2009 Ambulatory EHR Survey, p. 35-6.

¹⁹ It should be noted that these market share indicators may be different from the real market share distributions due to variable response rates among practices with specific products. The survey process could not estimate response rates by vendor or product.

organizations, 6.1% of clinicians), NextGen (28 clinician organizations, 7.6% of clinicians), Sage-Intergy (19 clinician organizations with 6.4% of clinicians) and Allscripts (18 clinician organizations, 13.4% of clinicians). Smaller market shares involve 22 vendors/products that are CCHIT-certified are serving 104 organization representing 16.2% of clinicians in clinician organizations covered by the survey. Thirty-two vendors/products that are **not** CCHIT-certified are serving 72 organizations representing 10.1% of clinicians in clinician organizations covered by the survey. Many of these non-certified products are focused on specific medical specialties.²⁰

**EHR Market Share of Clinicians – Clinician Organizations
(n=379 orgs, 2265 clinicians)**



Source: Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009

Upgrading an EHR system from an older version (certified or not certified) to the current version in the same product line is generally much less of a challenge than changing products or vendors. While this level of accuracy regarding certification is clearly suboptimal, it nevertheless provides some insight into the magnitude of EHR system installation or upgrade efforts that will be required to meet the requirements to receive Medicare or Medicaid incentive payments for demonstrating the meaningful use of certified EHRs.²¹

In the 2009 survey, overall 87.6% of the 5,139 clinicians are in organizations using EHR products that are part of certified product lines. While health system practice/clinics have the lowest rate of certified products (58.5%) from the survey, EHR system replacement projects currently under way will substantially increase this rate. Of greatest concern are the 250 (11.1%) of the 2,265 clinicians at clinician organization practices that are not certified under the previous CCHIT process, and would likely need to change EHR systems to qualify for incentive payments.

Adoption for other key provider types

²⁰ 2009 Ambulatory EHR Survey, p. 36-7.

²¹ 2009 Ambulatory EHR Survey, p. 39.

In addition to EHR adoption data from the 2009 Ambulatory EHR Survey, other sources have identified EHR adoption for tribal clinics, Veterans Administration health systems, and long-term care facilities. The State's HIE "system" is composed of a set of central services, rather than any kind of central infrastructure, network, or repository. These services include secure messaging services, provider directories, and trust services (to authenticate the identity of HIE trading partners, the security of their HIE technology, and the integrity of the data).

These State services do not necessarily require the use of an EHR product in order to access and utilize these services to perform HIE (though without an EHR product, HIE functionality would be limited). However, these HIE services are compatible with all certified EHR products and allow a more extensive HIE functionality than without such a system in place. To the extent that the VA and the tribal and IHS clinics use certified EHR products, their systems will be compatible with State HIE services.

EHR adoption for tribal clinics

Oregon has 10 tribal and Indian Health Service (IHS) clinics. These facilities are often in rural and isolated communities, and provide health care services to an expansive geographic area. Five tribal clinics use the IHS EHR Resource and Patient Management System (RPMS), in providing patient care. They include the following: Warm Springs Health Center, Warm Springs OR (IHS); Western Oregon Health Center, Chemawa, OR (IHS); Cow Creek Health & Wellness Center, Roseburg, OR (tribal); Yellowhawk Tribal Health Center, Pendleton, OR (tribal); and Siletz Community Health Center, Siletz, OR (tribal).²²

Most tribal and IHS clinics in Oregon use the IHS RPMS EHR system. This system has recently become certified through ONC. However, only the most recent version of RPMS is certified, and most clinics with an RMPS system will need to upgrade their system in order to have the certified version. This will take time, and will require the assistance of the tribal REC or Oregon's REC, O-HITEC, for many clinics.

EHR adoption for Veterans Administration health systems

The Veterans Administration (VA) operates the EHR systems VistA and My HealtheVet. The VA reported a 100% adoption rate in Oregon in Oregon's 2006 Ambulatory EHR survey.²³ As of this writing, VistA is certified as a complete EHR system for ambulatory practices and as a modular EHR for inpatient settings. It will take time for clinics needing to upgrade to a certified system to do so.

Data on providers eligible for Medicaid EHR incentives

In order to be eligible to receive Medicaid EHR incentive payments, providers must meet certain Medicaid and/or needy individual patient thresholds. Providers in FQHCs or RHCs can assess their "needy individual" patient volume – including Medicaid, Children's Health Insurance Program (CHIP), sliding scale care and uncompensated care. All other providers must count Medicaid patients only (not including CHIP). For pediatricians, a minimum 20% of patients must be Medicaid and/or needy individual patients. For all other eligible professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants in FQHCs/RHCs led by a physician assistant), a minimum of 30% of patients must be Medicaid and/or needy individual patients depending on the practice setting. For more information on eligibility requirements, see pages 39-52.

²² US DHHS Indian Health Services, Indian Health Services Directory, January 2011. Also, "IHS EHR Graphical User Interface Deployment Status" website, updated Jan. 20, 2011, accessed Jan. 26, 2011.

http://www.ihs.gov/cio/ehr/index.cfm?module=gui_facilities

²³ Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2006, p. 3. Prepared by David M. Witter, Jr., Witter & Associates. Available at: <http://www.oregon.gov/OHPPR/docs/OR2006EHRsurvey.pdf>

Oregon estimates that 856 EPs will receive Medicaid EHR incentive payments, resulting in \$43,263,860 in incentive payments through 2021. These analyses assume that all EPs/EHs who meet the patient volume thresholds will adopt, implement, or upgrade (AIU) to certified EHR technology and meet meaningful use requirements.

For more information, see Oregon’s IAPD Appendix C: Estimated Incentives to Oregon Providers. Oregon will continue to explore its modeling methods and update these estimates in future updates of its SMHP and IAPD.

Estimated total number of Eligible Professionals by Type and Setting

	Not FQHC/ RHC	FQHC	RHC	Both Settings	Total
Physicians (including Pediatricians) at 30% patient volume	280	132	35	NA	447
Additional Pediatricians at 20% patient volume	55	NA	NA	NA	55
Nurse Practitioners	15	86	12	NA	113
Dentists	NA	NA	NA	229	229
Physician Assistants	NA	0	12	NA	12
Totals	350	218	59	229	856

An earlier analysis came to similar conclusions about likely participation, though it estimated proportions of providers rather than specific numbers. That analysis is based on the 2009 Oregon Physician Workforce Survey, which gathered data on the estimated number of physicians eligible for Medicaid EHR incentives. A summary of the results of this analysis is included as Appendix C. Although analysis of these responses can provide some indication of the proportion of potentially eligible physicians, the responses do not distinguish between Medicaid and CHIP patients. Since eligible professionals not in FQHCs or RHCs must only count Medicaid and not CHIP patients in their patient volume, these numbers are likely to be inflated. In addition, these analyses do not consider the role of Medicare Advantage and provider eligibility for Medicare EHR incentives.

Oregon received 1,831 relevant responses, resulting in the following findings.

- 6.3% of independent physicians not in FQHCs or RHCs (not including pediatricians) would be eligible.
- 58.4% of independent pediatricians not in FQHCs or RHCs would be eligible.
- For practitioners in hospital-owned practices, 62.4% of physicians (not including pediatricians) would be eligible, and 92.6% of pediatricians would be eligible.
- Finally, 93.8% of physicians in FQHCs or RHCs would be eligible.²⁴

An updated initial analysis of the 2009 Oregon Physician Workforce Survey in April 2011 projected that as many as 705 physicians may be eligible based on Medicaid patient volume alone.

3. Hospital EHR adoption

The majority of Oregon’s 58 acute care hospitals, including the 25 critical access hospitals (CAHs), use EHRs. In

²⁴ Oregon Office of Health Policy and Research, Potential Medicare and Medicaid Incentive Payments Available to Oregon Eligible Professionals, prepared by David M. Witter, Jr., Witter & Associates. Updated December 1, 2010, p. 4.

2009, 47 of Oregon's 58 hospitals either already had an EHR in place or anticipated implementing one in 2010. These hospitals represent 95% of Oregon's 2008 hospital discharges. These hospitals' EHRs are provided by nine vendors, all of which have CCHIT-certified products. Eleven acute care hospitals did not have EHRs and did not have plans to implement one by 2010; eight of these are critical access hospitals. However, all 11 have indicated plans to implement over the next five years.²⁵

Multi-site

The highest penetration or rate of EHR adoption in Oregon is found in hospitals and large health systems. In 2009, there were nine multi-hospital health systems with 35 hospitals. Among these 35 hospitals, 30 have implemented EHR systems. By early 2010, seven health systems had robust deployment of EHRs that are certified by the CCHIT, covering 27 of the 35 hospitals. Among five of the remaining hospitals without an EHR, three have formal plans to implement by 2013. The remaining two hospitals plan to implement within the next two to five years. It is anticipated that five of these hospitals will accelerate their implementation timelines because of recent changes in federal policy, including incentives.²⁶

Data on hospitals eligible for Medicaid EHR incentives

Overall, Oregon estimates that as many as 57 of the 58 Oregon hospitals are expected to be eligible for Medicaid incentive payments totaling \$64,413,518 through 2021. To be eligible to receive a Medicaid incentive payment, acute care and critical access hospitals must meet two requirements. (For a more complete description of incentive program eligibility criteria for hospitals, see pages 39-43)

- First, they must have an average length of stay less than 25 days. All 58 Oregon hospitals currently meet this requirement and are expected to continue to do so.
- Second, a hospital must have at least 10% Medicaid patient volume. In 2009, analysis of Oregon hospital eligibility showed that, of Oregon's 58 hospitals, 49 would be eligible to receive Medicaid incentive payments, based on discharge rates. Thus, as many as nine of Oregon's hospitals may not be eligible to receive Medicaid incentives in 2011, due to low Medicaid patient volume. All but one of these nine hospitals may be able to meet patient volume requirements in the future, and have been included in Oregon's estimate.

These analyses assume that all hospitals that meet the eligibility criteria will adopt, implement, or upgrade (AIU) to certified EHR technology and/or meet meaningful use requirements.

²⁵ Oregon HIT Environmental Assessment, p. 5.

²⁶ Oregon HIE Strategic Plan, p. 27.

Potential Incentive Payments to Oregon Hospitals

Estimated Maximum Potential Medicare & Medicaid Incentive Payments to Oregon Hospitals with Meaningful Use in 2011, 2012, 2013 under the Final Rule (\$ in thousands) based on CY2009 data.				Potential Medicare			Eligible for Medicaid: >10% of Patient Discharges (5)		Potential Medicaid: Ignoring 10% Eligibility Requirement		Potential Medicare & Medicaid Combined Payments	
Health Systems (bold), Hospitals	Oregon Hospital Type (1)	Pymt Type	Location	Acute Discharges 2009	Year 1 (100%)	Over 4 Years	% Medicaid discharges	Eligible for Incentive (5)	Year 1 (100%)	Over 4 Years	Year 1 (100%)	Over 4 Years
DISCLAIMER: These estimates of potential incentive payments are based on available information regarding hospital volume and characteristics as well as information about Medicare and Medicaid rules. The amounts and actual results may vary substantially from these estimates based on the individual circumstances of particular hospitals, changes in rules and other known or unknown factors.												
Providence Health System			Portland									
Providence St Vincent Medical Ctr	DRG	PPS	Portland	29,136	2,735	6,839	10.2%	Y	619	1,547	3,354	8,385
Providence Portland Medical Ctr	DRG	PPS	Portland	20,209	2,944	7,361	12.5%	Y	703	1,758	3,648	9,119
Providence Medford Medical Center	DRG	PPS	Medford	5,626	1,920	4,799	14.6%	Y	399	998	2,319	5,797
Providence Willamette Falls Hospital (2)	DRG	PPS	Oregon City	5,116	1,312	3,279	19.9%	Y	511	1,277	1,822	4,556
Providence Milwaukie Hospital	DRG	PPS	Milwaukie	2,910	1,307	3,269	19.7%	Y	430	1,075	1,737	4,344
Providence Newberg Hospital	Type B	PPS	Newberg	2,062	1,133	2,832	16.3%	Y	281	702	1,414	3,534
Providence Hood River Memorial Hospital	Type B	CAH	Hood River	1,674	unknown	unknown	23.0%	Y	423	1,057	unknown	unknown
Providence Seaside Hospital	Type B	CAH	Seaside	935	unknown	unknown	12.3%	Y	221	553	unknown	unknown
Total - Providence Health System				67,668	11,351	28,378			3,586	8,966	14,294	35,734
Legacy Health System			Portland									
Legacy Emanuel Hospital & Hlth Ctr	DRG	PPS	Portland	17,896	1,038	2,595	27.1%	Y	1,747	4,368	2,785	6,962
The Children's Hospital at Legacy Emanuel			Portland	included with Legacy Emanuel Hospital								
Legacy Good Samaritan Hosp & Med Ctr	DRG	PPS	Portland	10,898	2,123	5,307	7.3%	N	326	816	2,449	6,122
Legacy Meridian Park Hospital	DRG	PPS	Tualatin	8,191	1,936	4,841	5.9%	N	194	484	2,130	5,325
Legacy Mount Hood Medical Center	DRG	PPS	Gresham	5,847	1,450	3,625	19.4%	Y	547	1,367	1,997	4,992
Total - Legacy Health System				42,832	6,547	16,366			2,814	7,035	9,360	23,401
Oregon Health & Science University			Portland									
OHSU Hospital	DRG	PPS	Portland	29,290	1,976	4,940	23.2%	Y	1,623	4,056	3,599	8,997
Doernbecher Children's Hospital			Portland	with OHSU Hospital								
Total - Oregon Health & Science University				29,290	1,976	4,940			1,623	4,056	3,599	8,997
PeaceHealth, Oregon & Siuslaw Regions			Eugene									
Sacred Heart Medical Ctr River Bend	DRG	PPS	Eugene	23,770	3,030	7,575	16.2%	Y	1,218	3,045	4,248	10,620
Sacred Heart Medical Ctr Univ Dist	DRG	PPS	Eugene	2,970	1,115	2,789	21.1%	Y	597	1,493	1,713	4,282
Peace Harbor Hospital	Type B	CAH	Florence	1,324	unknown	unknown	11.4%	Y	185	462	unknown	unknown
Cottage Grove Community Hospital	Type B	CAH	Cottage Grove	410	unknown	unknown	8.5%	N	149	373	unknown	unknown
Total - PeaceHealth				28,474	4,145	10,363			2,149	5,372	5,960	14,901
Asante Health System			Medford									
Rogue Valley Medical Center	DRG	PPS	Medford	13,958	2,468	6,171	15.5%	Y	837	2,093	3,306	8,264
Three Rivers Comm Hospital	DRG, Type	PPS	Grants Pass	7,379	2,109	5,273	16.3%	Y	484	1,211	2,594	6,484
Total - Asante Health System				21,337	4,578	11,444			1,321	3,304	5,899	14,748

Oregon State Medicaid HIT Plan - Environmental Scan

Potential Incentive Payments to Oregon Hospitals

Salem Health												
Salem Hospital	DRG	PPS	Salem	20,218	2,904	7,260	15.6%	Y	1,018	2,545	3,922	9,805
West Valley Hospital	Type B	CAH	Dallas	93	unknown	unknown	5.4%	N	94	236	unknown	unknown
Total - Salem Health				20,311	2,904	7,260			1,112	2,781	3,922	9,805
Samaritan Health Services, Inc.												
				Corvallis								
Good Samaritan Regional Medical Center	DRG	PPS	Corvallis	7,939	1,947	4,867	10.5%	Y	370	924	2,316	5,791
Samaritan Albany General Hospital	DRG	PPS	Albany	3,344	1,342	3,356	27.6%	Y	590	1,475	1,932	4,831
Samaritan Lebanon Community Hospital	Type B	CAH	Lebanon	1,859	unknown	unknown	25.9%	Y	461	1,153	unknown	unknown
Samaritan North Lincoln Hospital	Type B	CAH	Lincoln City	1,288	unknown	unknown	22.2%	Y	475	1,187	unknown	unknown
Samaritan Pacific Communities Hospital	Type B	CAH	Newport	1,371	unknown	unknown	27.6%	Y	466	1,165	unknown	unknown
Total - Samaritan Health Services, Inc.				15,801	3,289	8,222			2,362	5,905	4,249	10,621
St. Charles Health System												
				Bend								
St Charles Medical Center - Bend	DRG	PPS	Bend	13,836	2,193	5,484	12.2%	Y	587	1,467	2,780	6,950
St Charles Medical Center - Redmond	Type B	PPS	Redmond	2,350	1,292	3,231	15.2%	Y	265	663	1,557	3,894
Mountain View Hospital	Type B	CAH	Madras	1,113	unknown	unknown	27.6%	Y	518	1,294	unknown	unknown
Pioneer Memorial Hospital (P)	Type B	CAH	Prineville	758	unknown	unknown	19.1%	Y	283	709	unknown	unknown
Total - Cascade Healthcare Community				18,057	3,486	8,715			1,653	4,132	4,338	10,844
Kaiser Permanente Northwest												
				Portland								
Kaiser Sunnyside Medical Center (4)	DRG	PPS	Clackamas	18,854	2,637	6,593	2.1%	N	121	303	2,758	6,896
Total - Kaiser Permanente Northwest				18,854	2,637	6,593			121	303	2,758	6,896
Adventist Health Northwest												
				Portland								
Adventist Medical Center	DRG	PPS	Portland	8,988	1,740	4,351	16.7%	Y	624	1,561	2,365	5,912
Tillamook County General Hospital	Type A	CAH	Tillamook	1,102	unknown	unknown	11.2%	Y	171	429	unknown	unknown
Total - Adventist Health Northwest				10,090	1,740	4,351			796	1,990	2,365	5,912
Catholic Health Initiatives												
				Roseburg								
Mercy Medical Center	DRG, Type	PPS	Roseburg	7,617	2,094	5,236	23.1%	Y	564	1,411	2,659	6,647
St Anthony Hospital	Type A	CAH	Pendleton	1,794	unknown	unknown	23.0%	Y	290	725	unknown	unknown
Total - Catholic Health Initiatives				9,411	2,094	5,236			854	2,136	2,659	6,647
Trinity Health												
				Ontario								
Holy Rosary Medical Center (3)	Type A	PPS	Ontario	2,836	1,435	3,588	23.6%	Y	392	980	1,827	4,568
St Elizabeth Health Services (3)	Type A	CAH	Baker City	754	unknown	unknown	15.4%	Y	245	613	unknown	unknown
Total - Trinity Health				3,590	1,435	3,588			637	1,593	1,827	4,568

Other Hospitals												
Bay Area Hospital	DRG	PPS	Coos Bay	7,648	2,051	5,128	17.4%	Y	525	1,313	2,577	6,441
McKenzie-Willamette Medical Center	DRG	PPS	Springfield	6,597	991	2,476	12.5%	Y	348	870	1,338	3,346
Sky Lakes (Merle West) Medical Center	DRG	PPS	Klamath Falls	6,066	1,574	3,934	22.7%	Y	584	1,459	2,157	5,393
Tuality Healthcare	DRG	PPS	Hillsboro	5,161	1,468	3,670	19.7%	Y	428	1,069	1,896	4,739
Willamette Valley Med Ctr	DRG, Type	PPS	McMinnville	4,161	1,603	4,007	16.3%	Y	322	805	1,925	4,812
Silverton Hospital	Type B	PPS	Silverton	3,728	356	890	36.6%	Y	972	2,429	1,328	3,319
Mid-Columbia Medical Center	Type B	PPS	The Dalles	2,277	1,204	3,010	23.6%	Y	428	1,071	1,632	4,081
Good Shepherd Medical Center	Type A	CAH	Hermiston	2,212	unknown	unknown	25.2%	Y	466	1,166	unknown	unknown
Columbia Memorial Hospital	Type B	CAH	Astoria	1,804	unknown	unknown	14.6%	Y	261	653	unknown	unknown
Grande Ronde Hospital	Type A	CAH	LaGrande	1,718	unknown	unknown	15.5%	Y	293	733	unknown	unknown
Ashland Community Hospital	Type B	PPS	Ashland	1,641	1,196	2,989	14.7%	Y	255	639	1,451	3,628
Santiam Memorial Hospital	Type B	PPS	Stayton	1,017	630	1,576	18.7%	Y	316	791	947	2,367
Coquille Valley Hospital	Type B	CAH	Coquille	704	unknown	unknown	13.2%	Y	162	406	unknown	unknown
Wallowa Memorial Hospital	Type A	CAH	Enterprise	482	unknown	unknown	10.4%	Y	156	391	unknown	unknown
Curry General Hospital	Type A	CAH	Gold Beach	753	unknown	unknown	16.7%	Y	300	749	unknown	unknown
Lower Umpqua Hospital	Type B	CAH	Reedsport	543	unknown	unknown	6.3%	N	164	409	unknown	unknown
Lake District Hospital	Type A	CAH	Lakeview	436	unknown	unknown	12.8%	Y	201	504	unknown	unknown
Southern Coos Hospital & Health Center	Type B	CAH	Bandon	407	unknown	unknown	5.4%	N	131	327	unknown	unknown
Harney District Hospital	Type A	CAH	Burns	549	unknown	unknown	6.6%	N	105	263	unknown	unknown
Blue Mountain Hospital	Type A	CAH	John Day	366	unknown	unknown	12.8%	Y	281	702	unknown	unknown
Pioneer Memorial Hospital (H)	Type A	CAH	Heppner	74	unknown	unknown	8.1%	N	161	402	unknown	unknown
Total - 58 Oregon Hospitals				334,059	57,254	143,136			25,887	64,717		
Total - 48 Oregon Hospitals Eligible for Medicaid Incentives with 10% or more Medicaid Discharges									24,442	61,106		
Footnotes												
(1) Hospital Types												
DRG: DRGs, hospitals are reimbursed a flat weight based on a patient's diagnosis and treatment. DRG hospitals are generally located in urban areas and have more than 50 beds.												
The Office of Rural Health has defined a hospital as rural if it is at least 10 miles outside the center of a city of 40,000 or more population.												
Rural hospitals are classified as Types A, B, or C for Medicaid reimbursement purposes.												
Type A: Rural hospitals that have 50 beds or less and are greater than 30 miles from another acute inpatient facility are reimbursed at 100% of reasonable cost by Medicaid.												
Type B: Rural hospitals with 50 or fewer beds and located 30 miles or less from another acute inpatient care facility are reimbursed at 100% of cost by Medicaid.												
Type C: Rural hospitals with more than 50 beds, but are not a referral center. These hospitals are treated as DRG hospitals for Medicare and Medicaid reimbursements for services.												
CAH (Critical Access Hospital): CAHs are 25 or fewer beds and located 35 miles or more (15 miles for mountainous terrain or areas with only secondary roads) from another hospital or CAH.												
CAHs must meet a number of other criteria and requirements and be formally designated as a CAH. CAHs receive enhanced Medicare reimbursement at 101% of reasonable costs.												
Source: Oregon's Acute Care Hospitals Capacity, Utilization and Financial Trends, 2005 to 2007. Office for Oregon Health Policy and Research, April 2009, pp. 1-4.												
Available at http://oregon.gov/OHPPR/RSCH/docs/Hospital_Report/Hospital_Report_2009.pdf .												
(2) Joined the Providence Health System effective October 1, 2009.												
(3) Transferred from Catholic Health Initiatives to Trinity Health effective March 31, 2010.												
(4) Kaiser Sunnyside Med Cntr ARRA payments estimated assuming zero charity care given limitations in Kaiser DataBank information.												
(5) >10% Patient Volume Required to receive any Medicaid incentive payments. This calculation based on discharges.												

Potential Incentive Payments to Eligible Professionals

Potential Medicare and Medicaid Incentive Payments Available to Oregon Eligible Professionals

Updated December 1, 2010

The American Recovery and Reinvestment Act of 2009 (ARRA) establishes incentive payments through Medicare and Medicaid for the meaningful use of certified electronic health record (EHR) technology by “eligible professionals and hospitals”. The Congressional Budget Office (CBO) estimates outlays for the combined Medicare and Medicaid incentives to be \$34 billion over fiscal years 2009 through 2016.

I. Medicare Incentive Payments

“Eligible Professionals” (predominantly physicians) may receive Medicare incentive payments of up to 75% of allowed **Part B** charges for demonstrating the “meaningful use” of certified EHRs. “Meaningful EHR use” is defined as: use of a certified EHR, including electronic prescribing, electronic exchange of health information to improve quality of health care such as promoting care coordination, and submission of clinical quality and other required measures in accordance with Final Rules from Centers for Medicare and Medicaid (CMS) issued in July 2010. The CMS EHR incentive payments website is available at <http://www.cms.gov/EHRIncentivePrograms/>.

Key definitions, phasing and processes regarding certified EHRs, meaningful use, health information exchange and quality measures are specified in the rules from the CMS and the Federal Office of the National Coordinator (ONC) for Health Information Technology.

Eligible Professionals: Medicare physician incentives payments provide up to \$44,000 per eligible professional over five years for demonstrated meaningful use beginning in 2011 or 2012. The maximum payments over the five years are year 1: \$18,000, year 2: \$12,000, year 3: \$8,000, year 4: \$4,000 and year 5: \$2,000. The maximum payments are lower if meaningful use criteria are first demonstrated in 2013 (\$42,000) or 2014 (\$35,000). For eligible professionals practicing in health profession shortage areas, the incentive payments amounts are increased by 10% (year 1: \$19,800, five year maximum \$48,400). Incentive payments are equal to 75% of the allowed Part B charges during the reporting year. No incentive payment may be made to a hospital-based eligible professional such as a pathologist, anesthesiologist or emergency physician who furnishes substantially all services in a hospital setting (inpatient or outpatient) through the use of facilities and equipment supplied by the hospital, including qualified electronic health records.

To receive the maximum first year incentive payment of \$18,000, an eligible professional would need to (a) meet the meaningful use criteria and (b) provide \$24,000 of allowed **Part B** charges.

II. Medicaid Incentive Payments

ARRA specifies parameters for Medicaid incentive payments but states have some latitude in structuring the incentive program to meet the special needs of their Medicaid populations. The Oregon Medicaid program is in the process of determining how it plans to implement Medicaid incentive payments. Information about the Oregon Medicaid incentive payments program is available at <http://www.oregon.gov/DHS/mhit/incentive.shtml>.

Eligible Professionals: Medicaid provider incentive payments provide up to \$63,750 per eligible professional over six years. Providers must qualify for incentives no later than 2016 to receive maximum payments. In year 1 of participation providers must either adopt/implement or upgrade to a certified EHR and demonstrate meaningful use to receive an incentive, and then demonstrate meaningful use in years 2-6 to continue to receive incentives. Payment amounts are: year 1: \$21,250, years 2-6: \$8,500 per year.

Medicaid incentive payments are available to physicians and other practitioner (including nurse practitioners, dentists, certified nurse midwives, and physicians' assistants in certain settings) that (a) meet the meaningful use of certified EHR criteria and related criteria, and (b) serve a sufficient proportion of Medicaid clients. These eligibility levels vary by the type of physician/provider practice setting as follows:

- Professionals other than pediatricians: a minimum of 30% Medicaid population but not including Children's Health Insurance Program (CHIP) clients.
- Pediatricians: a minimum of 20% Medicaid population but not including CHIP clients.
- Federally qualified health center (FQHC) or rural health clinic (RHC): a minimum of 30% "needy individuals" including Medicaid, Children's Health Insurance Program (CHIP), uninsured sliding scale or free care.

Similar to Medicare, no incentive payment may be made to a hospital-based eligible professional such as a pathologist, anesthesiologist or emergency physician who furnishes substantially all services in a hospital inpatient or emergency room setting through the use of facilities and equipment supplied by the hospital, including qualified electronic health records.

III. Medicare and/or Medicaid Incentive Payments

Eligible Professionals that are eligible for both Medicare and Medicaid incentive payments must choose whether they wish to receive Medicare or Medicaid payments. Providers cannot receive payments from both programs.

IV. Potential Incentive Payments for Oregon Providers

Oregon Physician Eligibility for Incentive Payments

The 2009 Oregon Physicians Workforce Survey (PWS) included questions that can help estimate the likely numbers of Oregon physicians that may be eligible to receive Medicare or Medicaid incentive payments. Attachment A shows the number of PWS responses by specialty and practice settings as well as the percentage of those physicians that could be eligible to receive incentive payments from Medicare or Medicaid. Attachment A also shows the percentage of physicians that could qualify in either Medicare or Medicaid:

- 81% of physicians in private clinics or offices could be eligible for either Medicare or Medicaid incentive payments assuming they utilize a certified EHR system and meet the meaningful use and other criteria.
- 97% physicians in FQHCs or RHCs, and
- 95% of physicians in hospital ambulatory care clinics could be eligible for incentive payments.

Caution: actual eligibility for incentive payments and the amounts of the payments is critically dependent on the adoption of certified EHR systems and satisfying meaningful use and other criteria. Additionally, providers may incur significant costs to adopt EHR systems and demonstrate meaningful use.

The 2009 Ambulatory EHR Inventory provides additional information about the levels of EHR adoption. The survey is available at <http://www.oregon.gov/OHPPR/HITOC/docs/OR2009EHRSurvey.pdf>.

IV. Oregon and Federal Health Reform Impacts

The 2009 Oregon Legislature enacted legislation to expand coverage under the Oregon Health Plan and provide other forms of health reform. The expansion in the Oregon Health Plan and Medicaid program is likely to increase the number of professionals that may be eligible to receive Medicaid incentive payments, assuming those professionals meet the meaningful use criteria. Similarly, Federal health reforms included in the Patient Protection and Affordable Care Act of 2010 are likely to affect the volumes of Medicaid patients in many practice settings.

Oregon Medicaid HIT EHR Survey

Medicaid HIT Stakeholder Internet Survey, November 2010 Executive Summary

On Nov. 19, 2010, the Medicaid Health Information Technology (HIT) project invited Oregon stakeholders to participate in a web-based survey. The survey was sent via e-mail to 1,057 stakeholders, targeting DMAP eligible professional types, hospitals, MCOs, professional organization representatives and key stakeholder organizations. The survey closed Nov. 29th. The survey received a total of 137 responses (overall response rate of 13%); 86 completed the entire survey.

The purpose of the survey was to obtain quick feedback that would inform and guide the project's analysis activities. Responses from the survey were not intended to be a representative sample from which program decisions would be based. Additional scanning work, including surveys will be completed on an ongoing, annual basis.

The general respondent make-up included a relatively balanced response rate from urban/rural providers and from those who worked in Federally Qualified Health Centers/Rural Health Centers. Survey respondents represented the following areas:

Respondent Type	Number	Proportion
Individual health care providers	36	26%
Group representatives such as clinic, managed care organization, or health care professional representatives	48	35%
Other stakeholders	41	30%
Hospital representatives	12	9%
Total	137	100%

Key survey areas included provider eligibility, focusing on patient volume methodologies; hospital eligibility; and project communication and outreach. The survey was also used to gain a general understanding of provider demographics and characteristics.

Patient Volume Methodology

Individual health care providers, group representatives, and stakeholders were asked a series of questions surrounding the patient volume methodology decision that Oregon has to make. To qualify for an incentive payment, Medicaid patient volume must be at least 30%. The decision is whether to offer a method of "Patient Encounter" or a choice between "Patient Encounter" or "Patient Panel" to calculate Medicaid patient volume. Questions surrounding which method would be chosen, rating of the difficulty or ease of calculating the patient panel method, opinion on what decision Oregon should make, as well as alternate methodologies were asked. Additional questions were asked to determine whether providers felt inclusion of out-of-state patients in the patient volume calculation would make a substantial difference in a provider qualifying for the EHR Incentive program.

While the majority (61%) of the respondents reported they would choose the Patient Encounter method compared to a small handful (9%) who chose Patient Panel, most (53%) felt that Oregon should offer the choice compared to 7% who felt that only the Patient Encounter method should be offered; 40% were not sure. The majority of respondents (45%) were also not sure whether including out of state

patients would make a difference in whether a provider would qualify for the program. The higher number of answers of “not sure” offers the project an opportunity for additional provider outreach and communication.

Hospital participation

Hospitals were asked a series of questions surrounding detail of their EHR system status, eligible hospital type, Medicaid patient volume, and anticipated first year of participation. With the 12 responses, an overwhelming 92% reported that they either have or are in the process of obtaining an EHR system and 90% meet the definition of an Eligible Inpatient Acute Care Hospital. 40% of the respondents plan on participating in both the Medicare and Medicaid EHR incentives programs; the remaining 60% were not sure on program participation.

Communication and outreach

The majority of respondents across all surveys (over 50%) offered to partner with the Medicaid EHR Incentive program as an either resource or communication partner. The goal of the survey was inform providers about the program and to inform the project about provider’s perspectives surrounding various program aspects.

Survey Overview

The Medicaid EHR Incentives program survey was intended to inform the project on various program areas including:

- Respondent demographics such as size of clinic, type of providers, setting of practice
- Preferences and opinions for Oregon’s Patient Volume calculation methodology
- Assessment of provider respondent’s potential eligibility for the program
- Likelihood and expected timeframe of participation in the Medicaid EHR incentives program
- Preferences for communications and education outreach

Four survey types were used within the survey:

- Individual Eligible Professional (EP)
- Clinic Rep – Almost identical content as the Individual eligible professional survey but language revised slightly for clinic representatives, health care professional association representatives and managed care organization representatives
- Hospitals
- Stakeholders – Contains limited key questions from the Individual eligible professional and Clinic Rep surveys

The responses below are a summarization of all responses from each of the various surveys. Where applicable, answers to each question have been aggregated by survey type in each of the tables. The questions have been modified slightly to accommodate minor wording variations between the four surveys.

RESPONDENT DEMOGRAPHICS

1. Please identify the role that best describes you

Answer determined which of the four survey instruments would be presented to the respondent (see survey instrument key)

Answer Options	Response Count	Response Percent
A. Health care provider	36	26%
B. Clinic representative	33	24%
C. Hospital representative	12	9%
D. Health care professional association representative	6	4%
E. Hospital association representative	0	0%
F. Managed care organization representative	9	7%
G. Other stakeholder:	7	5%
Other (please specify)	34	25%
Totals	137	100%

Survey instrument key	
Identified Role	Survey Instrument
A. Health care provider	Individual EP
B. Clinic representative	Clinic rep
C. Hospital representative	Hospital
D. Health care professional association representative	Clinic rep
E. Hospital association representative	Stakeholder
F. Managed care organization representative	Clinic rep
G. Other stakeholder:	Stakeholder
Other (please specify)	Stakeholder

2. Please provide your zip code

Zip code was asked of all respondents within each of the survey instruments. Urban vs. rural designation is based on rural definitions located on the OHSU web site (<http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm>)

Urban vs. Rural										
Population Density based on zip code	Indiv EP		Clinic rep		Hospital		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%	#	%
Urban	24	65%	30	64%	3	25%	20	50%	77	57%
Rural	13	35%	17	36%	9	75%	18	45%	57	42%
Other* - Out of state	0	0%	0	0%	0	0%	2	5%	2	1%
Totals	37	27%	47	35%	12	9%	40	29%	136	100%

* Other zip codes were for Vancouver, WA and Fresno, CA

3. How many clinicians practice in your clinic?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Solo Practice	5	14%	2	7%	7	11%
2-4 Clinicians	7	20%	1	4%	8	13%
5-9 Clinicians	6	17%	7	25%	13	21%
10-19 Clinicians	5	14%	8	29%	13	21%
20-49 Clinicians	6	17%	5	18%	11	17%
50+ Clinicians	6	17%	5	18%	11	17%
Totals	35	56%	28	44%	63	100%

4. Please select which provider type best describes you or types of health care clinicians you represent.

Note: Respondent could select as many answer options applied.

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Physician	16	35%	31	41%	22	25%	69	33%
Pediatrician	2	4%	10	13%	7	8%	19	9%
Dentist	0	0%	4	5%	6	7%	10	5%
Nurse practitioner	7	15%	0	0%	25	28%	32	15%
Certified nurse-midwife	5	11%	5	7%	5	6%	15	7%
Physician assistant	4	9%	11	15%	9	10%	24	11%
Other (please specify)*	12	26%	14	19%	12	14%	38	18%
Not applicable	0	0%	0	0%	2	2%	2	1%
Totals	46	22%	75	36%	88	42%	209	100%

Other Responses* Individual EP	Clinic Rep	Stakeholder
1. Administrator	1. Behavioral health clinicians	1. All
2. Chemical dependency therapist	2. Health information management professionals	2. ASC, Laboratory, Radiology, EKG, Other ancillary services
3. Executive Management	3. LCSW	3. Long term care providers
4. Finance	4. Licensed Mental Health Professionals	4. Many of the above types of providers participate in the Telehealth Alliance of Oregon
5. Health department	5. Mental Health and Addictions	5. Nurses Mental Health Clinicians
6. Mental Health	6. Mental Health Organization	6. Nursing home, assisted living, residential care and in-home care providers
7. Mental Health Practitioner	7. Natural medicine providers, chiropractors	7. OAHN represents providers statewide in administering the \$20mm FCC Telehealth program
8. MSW	8. Nurse practitioner starting in July/Aug 2011	8. Psychiatrists
9. Peer Support Specialist	9. Psychiatrists, QMHPs, QMHA, LPCs	9. RN (2)
10. Practice Owner-Registered Nurse	10. Psychiatrist	10. We also employ public health nurses who provide communicable disease control services as well as patient care
11. Psychologist	11. QMHP	11. We represent the hospitals, clinics, community colleges as organizations.
	12. Social workers and case managers	
	13. We are an MCO	

5. Do you or any of the clinicians you represent practice in a Rural Health Center or Federally Qualified Health Center?

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Yes	7	20%	22	51%	17	47%	46	40%
No	25	71%	18	42%	13	36%	56	49%
Not Applicable	0	0%	1	2%	3	8%	4	4%
Not sure	3	9%	2	5%	3	8%	8	7%
Totals	35	31%	43	38%	36	32%	114	100%

6. Do you or any of the clinicians you represent practice in other states besides Oregon?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Yes	2	10%	6	17%	8	15%
No	18	90%	28	80%	46	84%
Not sure	0	0%	1	3%	1	2%
Total	20	36%	35	64%	55	100%

7. Do you or any of the clinicians you represent serve Medicaid patients from other states besides Oregon?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Yes	10	50%	11	31%	21	38%
No	10	50%	22	63%	32	58%
Not sure	0	0%	2	6%	2	4%
Total	20	36%	35	64%	55	100%

ELIGIBLE PROFESSIONALS PATIENT VOLUME METHODOLOGY

8. If given the choice, which method would you or your clinicians choose to calculate patient volume?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Patient Encounter	12	55%	23	66%	35	61%
Patient Panel	2	9%	3	9%	5	9%
Not sure	8	36%	9	26%	17	30%
Totals	22	39%	35	61%	57	100%

Respondent comments to this question by answer option:

Patient Encounter

- Generally needy patients receive more services, so a clinician with a panel with less than 30% needy patients should not be disqualified if over 30% of the services given are for the needy patients in his/her panel – respondent answered “encounter”
- As providers of maternity services, our patient "panel" is not as stable as providers providing services over a period of years.
- RHC is an urgent care clinic.
- Easier to get
- Easiest to calculate
- Often the "needy" and Medicaid patients are seen more often.
- We do not keep a list of # of assigned patients by provider.
- Ease of gathering information from schedules.

Not sure

- I need to look at our office statistics more carefully before we decide. We are working on this but are in the middle of switching to an EMR and haven't had time yet.
- As of the date of this survey response, we have not calculated patient volume of our provider group under either methodology. In light of the assumption of risk of our provider group under the OHP contract, we recommend the simplified member method set forth in our comment below.

Of the 5 respondents who chose Patient Panel:

- 3 of the 5 represented FQHC's/RHC's; 2 of the 3 were also Managed Care Organizations
- 2 answered that more clinicians would qualify if Oregon gave providers the choice of the Patient Panel calculation and felt the calculation was manageable. 2 respondents were not sure if more would qualify and responded that the Patient Panel calculation was easy. One respondent answered that the patient encounter methodology alone would likely cover all eligible professionals but also answered that the Patient Panel methodology was burdensome to use.

9. In your opinion, would more clinicians qualify for the program if Oregon gave providers the choice of the Patient Panel calculation method rather than only offering the Patient Encounter calculation method?

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Yes – Some providers would qualify with the Patient Panel methodology and wouldn't qualify with the Patient Encounter method	2	10%	7	20%	8	25%	17	19%
No – The Patient Encounter methodology alone would likely cover all eligible professionals	4	19%	4	11%	5	16%	13	15%
Not sure	15	71%	24	69%	19	59%	58	66%
Totals	21	24%	35	40%	32	36%	88	100%

Respondent comments to this question by answer option:

Yes – Some providers would qualify with the Patient Panel methodology and wouldn't qualify with the Patient Encounter method

- I think giving providers the most options is a good idea.
- Patient Encounter method appears to "favor" volume of encounters and might unfairly penalize providers that have smaller practices.
- Keep qualification criteria as broad as possible at least until details of eligibility and reimbursement are tested through simulation with a sound statistical foundation for the results

No – The Patient Encounter methodology alone would likely cover all eligible professionals

- We do not have Medicaid assigned patients in public health
- Over time the numbers should be almost identical anyway, yet far more cumbersome and likely more error-prone to calculate with the "panel" method
- Applied specifically to our group, acknowledge this may differ based on specialty/practice.

Not sure

- It would be much easier to gather data for the patient panel
- We do not base our services on patient volume

10. Please rate how easy or difficult it would be to calculate patient volume using the Patient Panel methodology?

Answer Options	Indiv ep		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Easy	3	15%	2	6%	2	8%	7	9%
Manageable	5	25%	15	48%	16	62%	36	47%
Burdensome	10	50%	12	39%	4	15%	26	34%
Quite difficult	2	10%	2	6%	4	15%	8	10%
Totals	20	26%	31	40%	26	34%	77	100%

Respondent comments to this question by answer option:

Manageable:

- It's slightly more complicated to calculate with the Patient panel, but I imagine providers wouldn't try it unless they failed with the Patient Encounter method.
- Smaller organizations would find the Panel method more difficult than those with IT staff to assist
- Doable but not as representative for anesthesiology practice.

Burdensome:

- What a clinician has on record goes in and out of date, sometimes quite rapidly. Generally, it is updated at the time of an encounter.
- For some practices it might also be quite difficult. Given change in patient payment status over time, it might be difficult to get accurate data
- We have very antiquated software with limited reporting capabilities. Yet to be determined with the tools we have
- Patient Panel methodology requires a robust patient encounter logging and auditing system. Not every facility would be able to participate because of technological barriers.
- We do not have patient panels here with the tribe (most tribes don't) as we serve a smaller population and have limited staff. Thus, patients see whoever is available. If we had to take all patients and put them on panels it would be very difficult for our system. We could assign folks to a specific provider but reality is that provider would not 'truly' be that individual's sole provider.

Quite difficult:

- This seems like it's more applicable for Managed care providers and not Fee for Service providers like me.
- Empanelment has been hard in our practice without an electronic health record and with many different providers. We have tried.
- Being a 10 month old RHC, the report generating capability of the Practice Management software is still somewhat puzzling.

No response:

- NA, 100% Medicaid
- No knowledge to place opinion.
- Can't tell until run "transactions" in variety of patient/provider scenarios, especially rural where fully burdened costs are not as easily determined and sample sizes are small.

11. In your opinion, what decision should Oregon make on patient volume calculation methodology?

Answer Options	Indiv ep		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Patient Encounter Only	1	5%	1	25%	2	6%	4	7%
Provider choice of Patient Panel or Patient Encounter	12	55%	3	75%	16	50%	31	53%
Not sure	9	41%	0	0%	14	44%	23	40%
Totals	22	38%	4	7%	32	55%	58	100%

Respondent comments to this question by answer option:

Provider Choice:

- Whatever makes more providers eligible is the best way to go.
- The meaning of "assigned to the provider" is not clear to me. Therefore I opt for a choice
- Ensures all could participate.

Not sure

- Per above comments
- It should be the same, so that you have the same basis to compare practices.
- Freedom
- If possible, a choice would be preferable. There are some systems (maybe Kaiser) for which the panel method would seem workable

11. Would including patients from other states qualify more providers where they may not qualify with Oregon patients alone?

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Yes	4	20%	7	20%	16	50%	27	31%
No	5	25%	14	40%	2	6%	21	24%
Not sure	11	55%	14	40%	14	44%	39	45%
Totals	20	23%	35	40%	32	37%	87	100%

Respondent comments to this question by answer option:

Yes

- Clinicians in border communities, such as mine, see a substantial # of residents from other states.

Not Sure

- Not important for my practice but will be critical for practices that practice on the border.
- I think it is possible that it could make a difference

An additional analysis was completed for the clinicians (Individual EP and Clinic Reps) who responded that they either practice (8) or see patients who reside (21) out of state to determine whether they felt including patients from other states would qualify more providers where they may not qualify with Oregon patients alone.

Answer Options	Practice out of state (8)		Serve patients who reside out of state (21)	
Yes	5	62.5%	8	38%
No	0	0%	3	14%
Not sure	3	38%	10	48%
Totals	8	100%	21	100%

13. Oregon is seeking input from stakeholders on possible alternative methodologies given the CMS criteria. If you have any ideas or would like to assist us, please comment below?

Indiv ep		Clinic rep		Stakeholder		Total responses	
#	%	#	%	#	%	#	%
2	22%	3	33%	4	44%	9	100%

Respondent comments to this question:

- 1) Choose a methodology that uses Patient Panel criteria, but allows for the provider to weight his/her volume if services are provided in a Rural areas.
- 2) Our provider group is responsible for approximately 170,000 members of which approximately 70,000 are Oregon Health Plan members (or 41% of our eligible members). We would like to qualify our provider group on this basis because of the full-risk capitat
- 3) Per wRVUs per CMS patient versus primary patient.
- 4) Please talk to a County FQHC like Benton County or Lane County that is fully integrated with mental health care
- 5) The encounter method seems the simplest, and that wins the day for me.
- 6) This does not relate to our type of business
- 7) We currently track our Medicaid percentage for MAC and do it based on the random survey days and tracking total number of clients seen and Medicaid clients seen that day
- 8) What about using the number of individuals covered under a provider's Mental Health Organization? For example, we are responsible for the mental health needs of all Oregon Health Plan members within our county as a result of our contract with our MHO, GO
- 9) Will discuss with fellow OHN Board members.

ELIGIBILITY

14. Do you believe that you or any of the clinicians you represent will be eligible for the Medicaid EHR Incentive Program?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Yes	12	63%	30	86%	42	78%
No	5	26%	0	0%	5	9%
Not sure	2	11%	5	14%	7	13%
Totals	19	29%	35	71%	54	100%

Respondent comments to this question by answer option:

Yes

- We have been exploring ways of purchasing EMR but the cost has been prohibitive. We are the only group in our hospital not using EMR.
- Our EHR will need to become certified, but they are planning to pursue this.
- They would prefer incentives come to the clinic rather than to them as individual practitioners

No

- My program is under development, and yet I can't pay the 38,000.00 to get it CCHIT certified

Not Sure

- That would be up to the SHS Administration
- I certainly hope so but it has not yet been established.
- Purchase of EHRS may be an issue due to lack of funds

The following questions (15-19) were only asked of hospitals in relation to their eligibility in particular areas.

15. Does your hospital have an Electronic Health Record (EHR) System?

Answer Options	Total Responses	
	#	%
Yes - We have an EHR system installed and operational	5	42%
Yes - We have an EHR system installed but not operational	0	0%
Yes - We are in the process of installing an EHR system	6	50%
No - We have no EHR system at this time	0	0%
Other (please specify)*	1	8%
Totals	12	100%

*Other: Currently upgrading to certified version of Epic EMR (current version is installed and

16. Is your Hospital's EHR system certified according to the recent ONC-ATCB certification system?

Answer Options	Total Responses	
	#	%
Yes – Our system is a certified EHR system	8	67%
Not sure - We have an EHR system but we do not know if it is certified	0	0%
Other (please specify)*	2	33%
Totals	12	100%

*Other:

- Will be upgrading to certified version in 2011 Q1
- McKesson is working to obtain certification

17. Please provide the name of the system and the version used by your hospital

Name of system	Version
Cerner	2007.19.12
Cerner	Millinium
CPSI	Latest
CPSI	
EPIC	
GE	Centricity
Meditech	Currently 5.4 upgrading to 6.0

Answer Options	Total Responses	
	#	%
Name of System	7	100%
Version	6	86%
Totals	13	

18. Does it appear that your hospital will meet the 10% Medicaid patient volume requirements?

Answer Options	Total Responses	
	#	%
Yes	7	70%
No	1	10%
Not Sure	2	20%
Totals	10	100%

19. Does your hospital meet the definition of an Eligible Inpatient Acute Care Hospital?

Answer Options	Total Responses	
	#	%
Yes	9	90%
No	0	0%
Not Sure	1	10%
Totals	10	100%

PARTICIPATION

20. Individual EP only: Do you plan to participate in Oregon’s Medicaid EHR Incentive Program?

Answer Options	Indiv EP Total responses	
	#	%
Yes	5	26%
Maybe, I’m still deciding whether to participate under Medicare or Medicaid.	6	32%
No, I plan to participate in the Medicare EHR Incentive Program.	2	11%
No, I do not plan to participate in either program.	0	0%
Not eligible	2	11%
Not sure	4	20%
Totals	19	100%

Respondent comments to this question by answer option:

Maybe, I’m still deciding whether to participate under Medicare or Medicaid

- This will be an employer decision, not employee

Not sure

- I think it is likely that my institution will participate in the Medicare program. I’m not sure that my practice would qualify to participate in a different category than the larger institution.

21. Hospital Only - Do you plan to participate in Oregon’s Medicaid EHR Incentive Program?

Answer Options	Total Responses	
	#	%
Yes, we plan on participating in both the Medicare and Oregon’s Medicaid EHR Incentive Programs.	4	40%
Yes, we plan on participating in Oregon’s Medicaid EHR Incentive Program only.	0	0%
No, we are not participating in either program.	0	0%
Not eligible	0	0%
Not sure	6	60%
Totals	10	100%

22. When would participation likely begin?

Answer Options	Indiv EP		Clinic rep		Hospital		Total responses	
	#	%	#	%	#	%	#	%
As soon as the program is available (expected summer 2011)	5	45%	7	33%	2	50%	14	30%
Before the end of 2011	2	18%	10	48%	2	50%	14	30%
2012	2	18%	2	10%	0	0%	14	30%
Not sure	2	18%	2	10%	0	0%	4	9%
Totals	11	14%	21	71%	4	20%	46	100%

COMMUNICATIONS PREFERENCES

23. Would your organization be willing to partner with the Medicaid HIT project to educate and communicate with hospitals/providers about the Medicaid HIT program?

Answer Options	Clinic rep		Hospital		Total # of responses	
	#	%	#	%	#	%
Yes	23	48%	10	83%	33	55%
Not at this time	25	52%	2	17%	27	45%
Totals	48	80%	12	20%	60	100%

Respondent comments to this question by answer option:

Yes

- Maybe
- Depending on scope of commitment
- Should work with our CIO
- Contact director

Not at this time

- More information would be needed prior to making such a commitment
- Need more information about what commitments this entails.
- I am new to the position

24. How would you like to receive updates on Oregon’s Medicaid EHR Incentive Program?

Answer Options	Indiv EP		Clinic rep		Hospital		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%	#	%
Regular email updates	30	45%	31	29%	11	31%	32	36%	104	35%
Webinars	12	18%	17	16%	9	25%	18	20%	56	19%
Medicaid EHR Incentive Program website, including FAQ’s (Frequently Asked Questions)	10	15%	19	18%	7	19%	19	21%	55	18%
Presentations at Association conferences or other meetings	5	8%	21	20%	4	11%	8	9%	38	13%
Brochures mailed	3	5%	9	8%	3	8%	8	9%	23	8%
Articles in Provider Matters from the Department of Medical Assistance Programs (DMAP)	6	9%	10	9%	2	6%	4	4%	22	7%
Totals	66	22%	107	36%	36	12%	89	30%	298	100%

Respondent comment to this question by answer option:

Presentations at Association conferences or other meetings

- Our clinicians will likely learn the most through internal meetings where the information is tailored towards how it affects our organization.

25. Would you like to subscribe to the MHIT website?

Answer Options	Indiv EP		Clinic rep		Hospital		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%	#	%
Yes	25	68%	35	74%	11	92%	27	66%	98	72%
No	12	32%	12	26%	1	8%	14	34%	39	28%
Totals	37	27%	47	34%	12	9%	41	30%	137	100%

26. Would you or someone in your organization be willing to partner with the Medicaid HIT project to provide additional input into the design of Oregon’s Medicaid EHR Incentive Program?

Answer Options	Total Responses	
	#	%
Yes	49	54%
Please ask me later	17	19%
Not at this time	24	27%
Totals	90	100%

Respondent comments to this question by survey type:

EP Indiv

- Will discuss with IT volunteer committee and designate member of that committee

Clinic rep:

- Would need to ask my providers but I must tell you their plates are overflowing already.

Stakeholder:

- County HHS management may be interested in assigning someone to assist, depending on a number of factors. it's worth discussing.
- Swamped with FCC RHCPP deployment.
- Please contact the Board and ask for the Director. He will be able to connect you with a provider level individual who can assist and represent all Oregon Tribes. Individual Tribes may still wish to be included in this focus group but this is a more likely place to start.
- Per previous notes, will take Board

GENERAL COMMENTS

We received a total of 16 general comments regarding the program

General Comments:

- 1) Plans such as Family Care should be included in the Medicaid pool for eligibility. Many of the families in the Portland Metro Area have been moved from OHP to Family Care to improve reimbursement to the providers and reduce the State's burden. However, reimbursement is almost as low as Medicaid.*
- 2) If there is any way to broaden the definition of health care provider to include therapists and social workers, that would make the program more inclusive for community mental health agencies*
- 3) Enterprise EHR systems for dental only have not been certified yet. We are working with vendors who assure us that certification will be attainable
- 4) For the impact that EHR has on primary care clinicians productivity (and thus the availability of health care in their community), the incentives are woefully inadequate. \$60K per year for 5 years might come close.
- 5) Continued coordination at the CMS, ONC level with the FCC and Department of Agriculture in their broadband incentive programs and how to build statewide networks (vs. silo's) to support the use of EMR and patient centered care.
- 6) We know more about the Medicare meaningful use criteria that we do the Medicaid program. We need more information before we can determine if we plan to participate
- 7) If we're not eligible, good luck getting us to go the extra reporting mile
- 8) We want to ensure that long term care providers are included.*
- 9) Please make sure that electronic capture and transmission of reportable diseases to local health departments is included in the design
- 10) For us it is a daunting task to choose an EHR and implement it into the practice. We are a RHC with 5 MDs, 1 DO, a NP and a PA. Very busy -- difficult to take on a project of this magnitude
- 11) FQHCs should be able to get incentive payments at clinic level rather than have them paid to individual clinicians
- 12) We are on the front end of our research and plan to upgrade in early 2012. We are already in contact with someone. Thanks
- 13) Interested in seeing Behavioral Health providers being included as EPs*
- 14) What measures are in place to ensure that the FQHC clinic receives the incentive \$ if their providers leave in the middle of the incentive cycle?
- 15) I need help!
- 16) PA's should be included since most CHC's use PA's

*The program rules discussed in this comment are set at the federal level. Oregon does not have any flexibility to change these rules



Oregon State Medicaid HIT Plan

Version 5 Addendum:

2014 CEHRT Flexibility Rule

Original Submission October 31, 2014

Revised Submission December 23, 2014

Introduction

The Oregon Health Authority is committed to complying with federal regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) to effectively administer and oversee the Oregon Medicaid Electronic Health Record (EHR) Incentive Program. This State Medicaid Health Information Technology Plan (SMHP) Addendum provides CMS with an overview of Oregon’s plan to address the new requirements for Program Year 2014.

On September 4, 2014, CMS published a Final Rule 42 CFR Part 495 (2014), *Medicare and Medicaid Programs; Modifications to Medicare and Medicaid EHR Incentive Programs for 2014 and Other Changes to the EHR Incentive Program; and Health Information Technology: Revisions to Certified EHR Technology Definition and EHR Clarification Changes Related to Standards* to the Federal Register, or the 2014 CEHRT Flexibility Rule. The changes specified in the 2014 CEHRT Flexibility Rule take effect on October 1, 2014. The following table contains a high-level overview of the Oregon policy and program decisions based on the 2014 CEHRT Flexibility Rule.

Summary of the 2014 CEHRT Flexibility Rule

Title	Description
Acceptable Certified EHR Technology (CEHRT) Edition	For Program Year 2014, providers that could not fully implement 2014 Edition CEHRT due to delays in EHR product availability or the inability to meet the Stage 2 Meaningful Use Summary of Care Measure have the option to use 2011 Edition CEHRT, or a combination of 2011 & 2014 Edition CEHRT.
Corresponding Objectives & Measures	The edition of CEHRT available to the provider dictates the stage and version of the meaningful use objectives and measures (and associated clinical quality measures) the provider is able to meet.
Stage 2 Meaningful Use Extension	Stage 2 will extend through Program Year 2016. Stage 3 Meaningful Use will begin in Program Year 2017.

Oregon’s Policy and Program Decisions for 2014 CEHRT Flexibility Rule

Oregon completed a comprehensive analysis of the final rule to identify communication, policy, process and technology impacts to the Oregon Medicaid EHR Incentive Program. The following tables contain summaries of the impacted areas and Oregon’s plan to address the impacts for Program Year 2014.

Policy Impacts & Plan

Policy Impacts	Plan
Program Year 2014 Grace Period Extension	<p>Oregon requests approval to extend the Program Year 2014 grace period for Eligible Professionals to May 31, 2015 and Eligible Hospitals to January 31, 2015 to allow more time for system upgrades and preparation time for providers:</p> <ul style="list-style-type: none"> • MAPIR system changes to accommodate the Flexibility Rule requirements will not be implemented until Feb/March 2015 in Oregon. • Providers choosing to report under the 2014 CEHRT Flexibility Rule will need additional time to understand the requirements and prepare to attest. Preparation will take longer because providers will need to gather new reports and documentation that support their attestations. <p>NOTE: Data that substantiates the grace period request are included in Appendix A.</p>
Oregon Administrative Rules	Oregon will update the Oregon Administrative Rules to incorporate and align with the 2014 CEHRT Flexibility Rule.
Public Health Reporting	Oregon policy will reiterate that providers are required to continue the process of enrolling with and reporting to Oregon Public Health as per the requirements of the meaningful use objectives related to public health reporting. Further, if a provider sent a test message to a Public Health Agency in a previous EHR reporting period and chooses to report 2013 Stage 1 objectives and measures or the 2014 Stage 1 objectives and measures under the CEHRT flexibility option, Oregon's policy will align with the CMS rule and not require the provider to send another test message to meet the public health measure(s) for Program Year 2014.

Process Impacts & Plan

Process Impacts	Plan
CMS-37 Incentive Payment Estimates	Oregon will review and revise projected quarterly incentive payment estimates as appropriate.
Implementation Advanced Planning Document Update (I-APD-U)	Oregon will submit an I-APD-U if additional funding is required to complete the work plan for implementing changes to the Medicaid EHR Incentive Program necessitated by the 2014 CEHRT Flexibility Rule.
Fiscal Services	Payment procedures will remain unchanged with regards to the 2014 CEHRT Flexibility Rule. If payments need to be recouped, the existing process will be followed. Reason for recoupment will be included in correspondence with the provider and if related to the 2014 CEHRT Flexibility Rule then the appropriate section of the rule will be referenced.
Appeals	The appeals process will remain unchanged with regards to the 2014 CEHRT Flexibility Rule.
Reports	See Technology Impacts and Plan

Technology Impacts & Plan

Technology Impacts	Plan
Medicaid Assistance Provider Incentive Repository (MAPIR)	<ul style="list-style-type: none"> MAPIR is the Oregon state level repository (SLR). The MAPIR Collaborative submitted business requirements to the technical vendor, and the teams have collaborated to establish a timeline for development, testing, and implementation. For Program Year 2014, the MAPIR workflow will be redesigned to prompt a provider to enter their CMS CEHRT ID early in the attestation process. Based on the CEHRT ID, MAPIR will determine the CEHRT Edition and present providers with corresponding options for attestation consistent with the 2014 CEHRT Flexibility Rule. Providers using a CEHRT flexibility option will be required to attest to a statement indicating they were unable to fully implement a 2014 Edition CEHRT. Oregon anticipates MAPIR system changes will be implemented in late February/ early March 2015.
Medicaid EHR Incentive Program Universe (Data Warehouse)	<p>For program reporting, Oregon uses a Medicaid EHR Incentive Program data universe. The reports will be impacted by changes to MAPIR due to the 2014 CEHRT Flexibility Rule. Oregon will update the reports to allow the program to report on the providers that have delayed implementing 2014 Edition CEHRT for allowable reasons: software development, certification, implementation, test, or release of the product by the EHR vendor.</p>

Communications Impact & Plan

Communications Impacts	Plan
Communications & Outreach Marketing Materials	<p>Oregon will revise communications & outreach materials to align with the 2014 CEHRT Flexibility Rule.</p>
Professional Organizations & Oversight Councils	<p>Oregon will distribute updated Program Year 2014 participation information to Oregon professional organizations, the Regional Extension Center, and the Oregon Health Information Technology Oversight Council to provide updated program information, encourage continued participation and clarify expectations.</p>
Public Health MU Website & Registration Site	<p>Oregon will update the content of the Public Health Meaningful Use website and Registration site in Fall 2014.</p>
Medicaid EHR Incentive Program Website	<p>Oregon will update the Medicaid EHR Incentive Program website in Fall 2014</p>
User Guides	<p>Oregon will update the Medicaid EHR Incentive Program User Guides in Fall 2014</p>
Provider Matters Updates	<p>Oregon issues program guidance through monthly communication updates, called Provider Matters. Oregon will include information about the 2014 CEHRT Flexibility Rule in the coming months.</p>



Oregon State Medicaid HIT Plan

Version 5 Addendum:

Modifications to Meaningful Use in 2015 through 2017

Submission to CMS on January 15, 2016

Introduction

The Oregon Health Authority is committed to complying with federal regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) to effectively administer and oversee the Oregon Medicaid Electronic Health Record (EHR) Incentive Program. This State Medicaid Health Information Technology Plan (SMHP) Addendum provides CMS with an overview of Oregon’s plan to address the new requirements for Stage 2 Modifications for program years 2015-2017.

On October 16, 2015, CMS published a Final Rule 42 CFR Parts 412 and 495 (2015), *Medicare and Medicaid Programs; Electronic Health Record Incentive Program - Stage 3 and Modifications to Meaningful Use in 2015 through 2017; Final Rules to the Federal Register*. The changes specified in the rule take effect on December 15, 2015. The following table contains a high-level overview of the Oregon policy and program decisions based on the *Modifications to Meaningful Use in 2015 through 2017*.

Summary of Modifications to Meaningful Use in 2015 through 2017

Title	Description
<p>Objectives and Measures</p>	<p>Upon the effective date of the rule, all providers are required to attest to a single set of objectives and measures (Modified Stage 2). There are 10 eligible professional (EP) and 9 eligible hospital (EH) objectives, including one consolidated public health reporting objective. In 2015, all providers must attest to objectives using EHR technology certified to the 2014 edition. Alternative exclusions and specifications within individual objectives are available for providers who were scheduled to be in Stage 1 of meaningful use in 2015 including:</p> <ul style="list-style-type: none"> • using a lower threshold for certain measures • excluding Stage 2 measures for which there is no Stage 1 equivalent or where a previous Stage 1 menu measure is now a requirement <p>In addition, thresholds for two Stage 2 measures have changed:</p> <ul style="list-style-type: none"> • The Patient Electronic Access measure 2 threshold has been changed from 5% to at least one patient seen by the EP or discharged from the inpatient or emergency department of an EH or critical access hospital (CAH) during the EHR reporting period views, downloads or transmits his or health information to a third party • (EPs only) The Secure Electronic Messaging 2 threshold has been changed from 5% to the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period
<p>EHR reporting period</p>	<p>Starting in 2015, the EHR reporting period for all providers will be based on the calendar year. The EHR reporting period for all providers will be any continuous 90-day period. EPs may select an EHR reporting period from January 1, 2015 through December 31, 2015. EHs may select an EHR reporting period from October 1, 2014 through December 31, 2015.</p>

Oregon’s Policy and Program Decisions for the Modifications to Meaningful Use in 2015 through 2017 Rule

Oregon completed a comprehensive analysis of the final rule to identify communication, policy, process and technology impacts to the Oregon Medicaid EHR Incentive Program. The following tables contain summaries of the impacted areas and Oregon’s plan to address the impacts for Program Year 2015 and beyond.

Policy Impacts & Plan

Policy Impacts	Plan
<p>Program Year 2015 Grace Period Extension</p>	<p>Background:</p> <ul style="list-style-type: none"> • Additional MAPIR system changes are not necessary for EPs attesting for an AIU payment for program year 2015. • Dual eligible hospitals cannot attest with Medicare until January 4, 2016, after which they can attest using MAPIR. Oregon has 27 dual eligible hospitals that fall into this category. • MAPIR system changes to accommodate the Modified Stage 2 requirements for EPs attesting to meaningful use will not be implemented until <u>May 31, 2016</u> in Oregon. Oregon has roughly 2400 unique EPs that have received at least one payment in the Medicaid EHR Incentive Program and require MAPIR to be updated. • MAPIR system changes to accommodate the Modified Stage 2 requirements for our one Medicaid only hospital will not be implemented until <u>September 30, 2016</u> in Oregon. • Oregon’s approved grace period in prior program years has been 90 days. <p>Based on the information above, Oregon requests approval to extend the Program Year 2015 grace period to the dates listed below. These dates contemplate a 90-day grace period from the date the systems (MAPIR and Medicare) are available to the providers:</p> <ul style="list-style-type: none"> – March 31, 2016 - For EPs who are attesting for a program year 2015 AIU payment and for EHRs that are dually eligible with Medicare – August 31, 2016 – For EPs who are attesting for a program year 2015 meaningful use payment – December 31, 2016 – For the Medicaid-only hospital
<p>Oregon Administrative Rules</p>	<p>Oregon will update the Oregon Administrative Rules to incorporate and align with the <i>Modifications to Meaningful Use in 2015 through 2017</i> as well as the new <i>Stage 3 Meaningful Use rules</i>.</p>
<p>Public Health Reporting</p>	<p>Oregon is evaluating the impact of the public health meaningful use objective modification for Stage 1 to our current CMS approved requirement to report to Oregon’s Public Health Department’s immunization registry. After our analysis is complete and if changes are necessary, Oregon will submit an updated SMHP to CMS for approval.</p>

Process Impacts & Plan

Process Impacts	Plan
CMS-37 Incentive Payment Estimates	Oregon will review and revise projected quarterly incentive payment estimates as appropriate.
Implementation Advanced Planning Document Update (I-APD-U)	Oregon will submit an I-APD-U if additional funding is required to complete the work plan for implementing changes to the Medicaid EHR Incentive Program necessitated by the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule.
Fiscal Services	Payment procedures will remain unchanged with regards to the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule. If payments need to be recouped, the existing process will be followed. Reason for recoupment will be included in correspondence with the provider and if related to the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule then the appropriate section of the rule will be referenced.
Appeals	The appeals process will remain unchanged with regards to the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule.
Reports	See Technology Impacts and Plan.

Technology Impacts & Plan

Technology Impacts	Plan
Medicaid Assistance Provider Incentive Repository (MAPIR)	<ul style="list-style-type: none"> MAPIR is the Oregon state level repository (SLR). The MAPIR Collaborative submitted business requirements to the technical vendor, and the teams have collaborated to establish a timeline for development, testing, and implementation. Oregon anticipates MAPIR system changes will be implemented in late May 2016.
Medicaid EHR Incentive Program Universe (Data Warehouse)	For program reporting, Oregon uses a Medicaid EHR Incentive Program data universe. The reports will be impacted by changes to MAPIR due to the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule. Oregon will update the reports to allow the program to report appropriately for new meaningful use objectives in accordance with the rule.

Communications Impact & Plan

Communications Impacts	Plan
Communications & Outreach Marketing Materials	Oregon will revise communications & outreach materials to align with the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule.
Professional Organizations & Oversight Councils	Oregon will communicate with Oregon professional organizations, the REC-like contractor for Technical Assistance to Medicaid providers, and the Oregon Health Information Technology Oversight Council to provide updated program information, encourage continued participation and clarify expectations.
Public Health MU Website & Registration Site	Oregon will keep the content of the Public Health Meaningful Use website and Registration site up to date.
Medicaid EHR Incentive Program Website	Oregon will update the Medicaid EHR Incentive Program website in Winter 2015/2016
User Guides	Oregon will update the Medicaid EHR Incentive Program User Guides in Spring 2016
Provider Matters Updates	Oregon issues program guidance through monthly communication updates, called Provider Matters. Oregon has included and will continue to include information about the <i>Modifications to Meaningful Use in 2015 through 2017</i> rule.



Oregon State Medicaid HIT Plan

Version 5 Addendum:

2015-2017 Modifications Rule

Outpatient Prospective Payment System (OPPS) Rule

Medicare Quality Payment Program (QPP)

Submission to CMS on February 10, 2017

Introduction

The Oregon Health Authority is committed to complying with federal regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) to effectively administer and oversee the Oregon Medicaid Electronic Health Records (EHR) Incentive Program. This State Medicaid Health Information Technology Plan (SMHP) Addendum provides CMS with an overview of Oregon’s plan to address the new requirements for Program Year 2017 and beyond. Additionally, an overview is provided to address necessary updates for allowing pediatric optometrists to participate in the Oregon Medicaid EHR Incentive Program. Oregon received CMS approval 12/19/2016 under State Plan Amendment (SPA) 16-009 to allow optometric physicians to be considered the physician eligible professional (EP) type to the extent they provide services to children under 21, and meet other criteria required for the program.

CMS has requested States and Territories submit SMHP addendums for changes they anticipate making for 2017 related to the three recently released rules:

Modified Meaningful Use (MU) requirements for 2017: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2017ProgramRequirements.html>

OPPS Rule: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/OPPSOverview_Stage3.pdf

Medicare Quality Payment Program (QPP), also referred to as MACRA/MIPS: <https://qpp.cms.gov>

Summary of the CMS Requirements

Regulation and EHR Program Requirements	Brief Explanation of Requirement and SMHP Addendum Impact
A 2015-2017 Modifications Rule	
1 Option to attest to Stage 3 in 2017	Providers have the option to attest to Stage 3 in 2017. States should describe changes (program, system, policy, audit) being made to be prepared to address the option in 2017.
2 Program Year 2017 MU Requirements	2017 includes updates to the MU objectives and states need to discuss how they will administer attestations that include EHR period that are within 2017. NOTE: State Level Repository screen changes need to be submitted separately but by 2/10/17.
B OPSS Rule	
1 90-day EHR reporting period	All providers will attest to a 90-day EHR reporting for 2017. Define, design and submit any updates to SLR screens and preliminary audit strategy changes, along with policy updates pertaining to the 2017 “EHR reporting period” parameters.
2 Modification to measure calculation timeframe	Measure calculations were modified to require that actions included in the numerator must occur within the EHR reporting period. States should outline the changes (program, system, policy, audit) they are making to address this requirement.
C Medicare Quality Payment Program (QPP)	
1 Updates to definition of Meaningful EHR User	Definition now includes demonstration of supporting information exchange and prevention of information blocking. States should identify what changes (program, system, policy, audit) they will make to address updated definition within SMHP addendum.

2	Demonstration, via attestation, of updated Meaningful EHR user definition.	The Final Rule lists specific statements that providers participating in the Medicaid EHR Incentive programs must attest to for EHR reporting periods beginning in 2017. States must address changes (program, system, policy, audit) within SMHP addendum. NOTE: State Level Repository screen changes need to be submitted separately but by 2/10/17.
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Oregon’s Policy and Program Decisions

Oregon completed a comprehensive analysis of the changes afforded by the new CMS regulations and Oregon’s SPA 16-009 to identify program, system, policy, and audit impacts to the Oregon Medicaid EHR Incentive Program. The following tables contain Oregon’s plan to address the impacts.

2015 – 2017 Modifications Rule

Option to Attest to Stage 3 in 2017 & Program Year 2017 MU Requirements

Area	Plan
Program	<ul style="list-style-type: none"> • Oregon has already informed many Medicaid EHR Incentive Program participants of the program year 2017 MU requirements through the Rule Advisory Committee (RAC) meeting and webinar that was conducted 1/12/2017 as a means to inform stakeholders of new federal regulations and changes to Oregon Administrative Rules (OARs). • Oregon will continue to update communication materials including, program’s website, provider attestation checklists, targeted email, and informational webinar content in spring of 2017 to inform providers of the option to attest to Stage 3 meaningful use objectives for program year 2017. • Staff training on the new requirements has been completed.
System	<ul style="list-style-type: none"> • The thirteen-state Medical Assistance Provider Incentive Repository (MAPIR) Collaborative, which includes Oregon, presented screenshots to CMS on 1/18/2017 demonstrating the planned incorporation of Modified Stage 2 Program Year 2017 changes, as well as how providers will have the MU reporting option of either Modified Stage 2 or Stage 3. • Approval of the screenshots from CMS is pending. • Core MAPIR will be updated in summer of 2017 with the option for providers to attest to Stage 3 objectives.
Policy	<ul style="list-style-type: none"> • Oregon is in the process of updating the OARs to incorporate and align with the new CMS regulations related to MU. Current and historical OARs can be found at: http://www.oregon.gov/oha/healthplan/Pages/medicaid-ehr-policy.aspx.

OPPS Rule

90-Day EHR Reporting Period & Modification to Measure Calculation Timeframe

Area	Plan
Program	<ul style="list-style-type: none"> • Oregon has already informed many Medicaid EHR Incentive Program participants of the 90-day EHR reporting period and modification to measure calculation timeframes through the RAC meeting and webinar that was conducted 1/12/2017. • Oregon will continue to communicate the changes in communication materials including, program’s website, provider attestation checklists, and targeted email in spring of 2017. • Staff training on the new requirements has been completed.
System	<ul style="list-style-type: none"> • Core MAPIR was updated 1/1/2017 to incorporate the 90-day EHR reporting period; <ul style="list-style-type: none"> ○ For an EHR reporting period, providers select a starting date and the system calculates the ending date based on a continuous 90-day period. • Core MAPIR will be updated in summer of 2017 with the language referencing CMS regulations and the requirement that numerators reflect action taken during the EHR reporting period or the calendar year in which the EHR reporting period took place.
Policy	<ul style="list-style-type: none"> • Oregon is in the process of updating the OARs to incorporate and align with the new CMS regulations related to MU. Current and historical OARs can be found at: http://www.oregon.gov/oha/healthplan/Pages/medicaid-ehr-policy.aspx.

Medicare Quality Payment Program (QPP)

Updates to Definition of Meaningful EHR User & Demonstration, via Attestation, of Updated Meaningful EHR User Definition

Area	Plan
Program	<ul style="list-style-type: none"> • Oregon has already informed many Medicaid EHR Incentive Program participants of the updated meaningful user definition through the RAC meeting and webinar that was conducted 1/12/2017. • Oregon will continue to communicate the changes in communication materials including, program’s website, provider attestation checklists, and targeted email in spring of 2017. • Staff training on the new requirements has been completed.
System	<ul style="list-style-type: none"> • The thirteen-state MAPIR Collaborative presented screenshots to CMS on 1/18/2017 demonstrating the planned incorporation of required provider questions that will convey the updated definition of a meaningful EHR user. <ul style="list-style-type: none"> ○ The MAPIR questions capture providers’ responses regarding activities related to supporting providers with the performance of Certified EHR Technology (CEHRT), and actions related to supporting information exchange and the prevention of health information blocking.

	<ul style="list-style-type: none"> • Approval of the screenshots from CMS is pending. • Core MAPIR will be updated in summer of 2017 with the updates to the definition of a meaningful EHR user.
Policy	<ul style="list-style-type: none"> • Oregon is in the process of updating the OARs to incorporate and align with the new CMS regulations related to meaningful use. Current and historical OARs can be found at: http://www.oregon.gov/oha/healthplan/Pages/medicaid-ehr-policy.aspx.

Pediatric Optometrists as Eligible Professionals

On December 19, 2016, Oregon received CMS approval under SPA 16-009 to allow optometric physicians to be considered the physician EP type to the extent they provide services to children under 21, and meet other criteria required for the program. CMS also approved a retroactive effective date of July 1, 2016 to allow them to attest for program year 2016 incentive payments. Oregon has been completing the process to update OARs to allow pediatric optometrists to submit attestations for program year 2016.

Area	Plan
Program	<ul style="list-style-type: none"> • Oregon has been working closely with the Oregon optometrist association to inform them of the eligibility requirements and parameters of the Medicaid EHR Incentive Program. • Communication materials including the website, program year 2016 fact sheets, and pre-payment verification checklists have been updated to reflect pediatric optometrists are now considered the physician EP type. • Staff training on the new requirements has been completed.
System	<ul style="list-style-type: none"> • MAPIR has been configured to allow pediatric optometrists to attest for program year 2016 and beyond.
Policy	<ul style="list-style-type: none"> • Oregon is in the process of updating the OARs to incorporate pediatric optometrists as an eligible professional type for the program. Current and historical OARs can be found at: http://www.oregon.gov/oha/healthplan/Pages/medicaid-ehr-policy.aspx.



Oregon State Medicaid HIT Plan

Version 5 Addendum:

Naturopaths as Eligible Professionals

Submission to CMS on May 2, 2017

Introduction

The Oregon Health Authority (OHA) is committed to complying with federal regulations and guidance from the Centers for Medicare and Medicaid Services (CMS) to effectively administer and oversee the Oregon Medicaid Electronic Health Records (EHR) Incentive Program. In a phone discussion held on April 28, 2017 with David Meacham, Sam Schaffzin, and OHA, Oregon received verbal approval to include naturopaths as eligible professionals. This addendum will address Oregon’s plan for this change.

Naturopaths as Eligible Professionals

Oregon Medicaid has considered naturopaths as a provider of physician services since 1994 as stated in the State Medicaid Plan. In Oregon, as in several other states, they serve a critical role as Medicaid primary care providers and as such are reimbursed for covered Medicaid services according to the physician fee schedule. On April 28, 2017, Oregon received verbal CMS approval to allow naturopaths to be an eligible provider type. An updated State Plan Amendment (SPA) was not needed for this approval because naturopaths fall under the “Other Licensed Practitioner” authority. Oregon will begin allowing naturopaths to be an eligible professional type for the Medicaid EHR Incentive Program starting in program year 2016.

Due to the timing of the approval for naturopaths, Oregon is requesting a special tail period extension for naturopaths for program year 2016, and allow them to attest until July 31, 2017. Plans for implementing this change are described below

Area	Plan
Program	<ul style="list-style-type: none">• Oregon has been working closely with the Oregon Association of Naturopathic Physicians (OANP) to inform them of the eligibility requirements and parameters of the Medicaid EHR Incentive Program. Additional outreach and webinars will be offered to ensure we are reaching all eligible naturopaths.• Staff have been trained and understand Naturopaths are eligible for the program.
System	<ul style="list-style-type: none">• MAPIR will be configured to allow naturopaths to attest for program year 2016 and beyond.
Policy	<ul style="list-style-type: none">• Oregon is in the process of updating the Oregon Administrative Rules to incorporate naturopaths as an eligible professional type for the program. Current and historical OARs can be found at: http://www.oregon.gov/oha/healthplan/Pages/medicaid-ehr-policy.aspx.