State Health IT 1115 Toolkit – Key Questions with Detailed Background (V0.4.3)

Executive Summary

The State Health IT 1115 Toolkit ("Toolkit") enables states to examine the key building blocks needed to develop an optimized health IT ecosystem for advancing delivery system reform. An optimized health IT ecosystem includes heath IT, health information exchange (HIE) and data interoperability—amongst the state, managed care organizations (MCO), accountable care organizations (ACO), providers and beneficiaries.

The Toolkit includes three parts: (1) a summary of the key questions with detailed backgrounds; (2) state examples related to each of the relevant health IT topic areas; and (3) an Excel spreadsheet to assist states in their planning and coordination of health IT-related activities. The Toolkit also reinforces the need for the state to align its 1115 demonstration objectives with other projects or programs—such as State Innovation Model (SIM) activities, the Electronic Health Record (EHR) Incentive Program and Medicaid Management Information Systems (MMIS).

The toolkit addresses the following Health IT topic areas:

A. Promoting and Funding Provider Health IT Adoption and Use
B. The Use of Standards in Health Information Technology Procurement
C. Leveraging State Health IT Ecosystem
D. Accountable Oversight and Rules of Engagement for Health IT and Health Information Exchange (a.k.a. Governance)
E. Advancing Use of Health IT to Support Quality Measurement
F. Identity Management, Provider Directories and Attribution
G. Health IT and Service Delivery.

By using the Toolkit, states will ensure that they have adequately addressed the necessary elements for *sustainable* delivery system and payment reform. Using the toolkit is not a requirement, however, each state may be asked the same questions during review of the 1115 application.

CMS and the Office of the National Coordinator for Health IT (ONC) are available to discuss the use of the Toolkit, general health IT, HIE and interoperability considerations—as well as state-specific issues—and is ready to offer technical assistance, if needed. CMS and ONC would appreciate additional feedback on the use of the Toolkit.

For questions, technical assistance requests or suggestions, please contact Arun.Natarajan@hhs.gov.

DRAFT

How to Use This Document

This document provides detailed information on each of the fourteen questions raised in the EXCEL spreadsheet entitled "State 1115 Health IT Toolkit.xls". As States are reviewing each question in the excel spreadsheet, this document can be used as a resource. The "State Health IT 1115 Toolkit – Key Questions with Detailed Background" provides additional clarification associated with each question while the Addendum provides actual state examples associated with each of the Health IT topic areas.

The Toolkit provides states the opportunity to think through key health IT considerations as they plan their 1115 program. This document is a summary of the 14 key Health IT questions associated with 1115 demonstration topic areas. Grouped by subject areas, each question is further broken out in an excel spreadsheet by the four actors associated in this enterprise: the State, MCO/ACO, provider and the beneficiary.

As states begin working on an 1115 demonstration application, the state will most likely be required to discuss these questions with many individuals within the state, including the state's Health IT coordinator (if they have one), the state's legal team dealing with privacy, consent and security issues, the state's CIO, and others. The demonstration application team will also likely need to work with outside stakeholders to fully think through the HIE, interoperability and data sharing questions raised in this toolkit.

CMS and ONC are available to discuss these issues in greater detail upon request, including if states wish to identify the individuals to consult with from other states, from outside organizations, or even other people within the state.

Recommended Pre-Reading – Shared Nationwide Interoperability Roadmap

"Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap - Version 1.0."[1] *("The Roadmap") will help State staff more fully understand the context for the questions in this document. The Roadmap was informed by stakeholders nationwide to coordinate our collective efforts around health IT interoperability. It describes the policy and technical actions needed to realize our vision of a seamless data system.*

DRAFT

[1] https://www.healthit.gov/policy-researchers-implementers/interoperability

14 Key Questions to Ask in the 1115 Demonstration Program Design by Topic Area

A. Promoting and Funding Provider Health IT Adoption and Use

Any discussion of promoting health IT provider adoption and use must begin with the EHR Incentive program known as "Meaningful Use." The remainder of calendar year 2016 offers providers and states with a critical opportunity and challenge to advance health IT and EHR adoption and use with Medicaid providers. 2016 is the last year that an eligible professional can begin participation in the Meaningful Use EHR Incentive Program. CMS and states have collectively distributed $10.6 billion[2] incentive payments to Medicaid physicians to support health IT adoption. As required by the HITECH statute and in support of the EHR Incentive Program, CMCS is leveraging federal-state resources to advance the Medicaid enterprise and health information exchange. Considering MITA Condition and Standard # 4, 'the Leverage Condition'[3] or #7, 'the Interoperability Condition'[4], it is critical that states build off of the Meaningful Use EHR incentive program when promoting and funding provider health IT adoption and use. States should also consider leveraging MCO contracts as a means of supporting provider EHR adoption as described in the Medicaid Managed Care Final Rule[5].

1. *Does the demonstration provide direct provider incentives for EHR adoption use or indirectly through MCO contract requirements (either incentives or qualification/participation standards)?*

   Background:
   Health IT adoption and exchange of information aligning with national standards is explicitly called out in the Roadmap. As identified in the Roadmap, achieving nationwide interoperability to enable a learning health system requires that states and the federal government use health IT enabled value-based payment models as the dominant mode of payment and service delivery for providers.[6]"CMS has identified a number of ways that states can use Medicaid funds to develop care coordination capacity among their Medicaid providers, and several states have already begun to use Medicaid Managed Care contracts to advance interoperability[7]" through promoting EHR adoption. The Roadmap's Call to Action for states explicitly calls out leveraging Medicaid program funds to advance and support interoperability[8].

---

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html. More than $10.6 billion in Medicaid EHR Incentive Program payments have been made between January 2011 (when the first set of states launched their programs) and April 2016

[3] MITA Condition and Standard # 4, 'the Leverage Condition' requires states to promote sharing, leverage and reuse of Medicaid technologies and systems.

[4] MITA Condition and Standard #7, 'The Interoperability Condition' requires states to ensure a seamless coordination and integration with health information exchange, health insurance exchange and or other federal agencies.

[5] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-final-rule.html

[6] "The Roadmap" – pg.52.

[7] "The Roadmap" – pg.3.

[8] "The Roadmap" – pg. 52 (see A2. Calls to Action #2)

A well developed and effectively operated State plan to promote and incentivize Health IT provider adoption is critical to advancing the vision of nationwide Health IT interoperability. Federal and State funding coupled with State policy can advance provider infrastructure build outs for Health IT. The vision is that the State will develop and adopt a strategy to fund providers to adopt Health IT infrastructure and software to facilitate and improve integration and coordination between behavioral health, physical health, home and community based providers and community level collaborators for improved health outcomes, more efficient collaboration and a reduction of duplication and waste within the health and human services system.

2. *Does the State support EHR adoption or HIE onboarding for ACOs, MCOs, LTSS providers, EPs, and other ineligible MU providers? Does the SMA help Medicaid providers eligible for the EHR incentive programs but not yet enrolled have the health IT they need to share information with other providers? How?*
    a. *Do the activities described in the SMHP to help incentive eligible providers also support the 1115 efforts described here?*

Background:
EHR adoption can be translated as "better information means better health care". EHR adoption can be funded through an 1115 demonstration either directly or indirectly through higher reimbursement rates for providers that have adopted EHRs. EHR adoption benefits include more accurate and complete information about a patient's health, the ability to quickly provide care, the ability to better coordinate the care being given, and a way to share information with patients and their family caregivers.

Though EHR funding through an APD for ineligible MU providers is explicitly excluded per the State Medicaid Director Letter #16-003 " RE: Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers", HIE onboarding for ineligible MU Providers is something that can be funded. EHR funding can be directly paid for however through the 1115 demonstration itself. The CMS Medicaid Data and Systems Group and ONC Office of Policy have partnered to update the guidance on how states may support health information exchange and interoperable systems to best support Medicaid providers in attesting to Meaningful Use Stages 2 and 3. This updated guidance will allow Medicaid HITECH funds to support all Medicaid providers that Eligible Providers want to coordinate care with. Medicaid HITECH funds can now support HIE onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, and so on. It may also support the HIE on-boarding of laboratory, pharmacy or public health providers.[9]

A well developed and effectively operated State plan to promote and incentivize health IT provider adoption is critical to advancing the vision of nationwide health IT interoperability. Federal and State funding coupled with State policy can advance provider infrastructure build

[9] SMD #16-003 - : https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf ; PPT on SMD letter : https://www.healthit.gov/facas/sites/faca/files/HITJC_State_Medicaid_Director_Presentation_2016-04-19.pdf

outs for health IT. The vision is that the State will develop and adopt a strategy to fund providers to adopt health IT infrastructure and software to facilitate and improve integration and coordination between behavioral health, physical health, home and community-based providers and providers of services that impact health for improved care coordination.

Provider adoption is currently being supported for 'eligible providers', 'eligible hospitals', and 'critical access hospitals' as part of the Meaningful Use program. Other ways in which a State Medicaid Agency can promote provider health IT adoption would be as part of its managed care procurements and provider credentialing and certification standards.

There are multiple strategies for a State to choose from to promote health IT adoption [10] for both ineligible and eligible Meaningful Use providers, including federal financial participation (FFP) for health IT and HIE.

As it pertains to FFP for health IT and HIE, CMS is able to provide funding for State administrative activities related to the development of core HIE services (e.g., designing and developing a provider directory, privacy and security applications, and/or data warehouses), public health infrastructure, electronic Clinical Quality Measurement (mecum) infrastructure, and provider on-boarding. With respect to FFS for HIE policy, a State could determine, if appropriate, to pay providers that utilize HIE at a higher FFS rate than providers who do not, within applicable Federal payment limits. The associated costs must be factored into the service rates and are not separately payable. MCO HIE policy, the use of HIT and HIE can serve as significant vehicles for supporting State oversight and reporting on the quality of care to Medicaid beneficiaries in a managed care delivery system as part of both the State quality strategies and external quality review. Finally, Section 1115 has a great deal of latitude to promote health IT adoption. For example, collaboration with States recently resulted in special terms and conditions (STCs) for a State demonstration that hold a state and its managed care entities accountable for HIT adoption. With the 1115, CMCS and the State developed HIT adoption benchmarks as a part of a larger health reform effort in the State.

Certified EHR Technologies CEHRT

Providers adopting certified Health IT technologies may be more likely to be able to use Health IT to share clinical information with other providers. Use of ONC certified EHR and Health IT technology is mandatary for participating eligible providers as part of Meaningful Use or MU. The State should promote the use of CEHRT within this provider community. But not all eligible MU providers are enrolled in the EHR Incentive program or they may have dropped out after a year. Increasing the adoption of ONC certified technologies amongst eligible MU providers and assisting providers that may have dropped out of the EHR incentive program is important in advancing the health IT capacity of hospitals and eligible providers.

3. *Is the State providing technical assistance to support health information technology adoption amongst providers?*

States can support providers through technical assistance and HIE mandates to advance health information sharing amongst providers. In some states mandated enrollment in an HIE also

[10] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/health-information-exchange.html

places a responsibility on the part of the HIE to provide some level of technical assistance to enrolling providers.

Background:
Multiple States use IAPD funding to provide resources and support to providers in the EHR and health IT adoption process (i.e. REC-like services). The ONC's Regional Extension Centers (RECs), located in every region of the country, serve as a support and resource center to assist providers in EHR implementation and Health IT needs. As trusted advisors, RECs "bridge the technology gap" by helping providers navigate the EHR adoption process from vendor selection and workflow analysis to implementation and meaningful use.[11]

REC support has resulted in over 100 million patients having access to:

- Electronic prescriptions, resulting in reduced medication related errors;
- Patient visit summaries, allowing patients to more fully understand and participate in their health;
- Evidence-based care recommendations based on quality measures and indicators.

As trusted advisors to providers in local communities, RECs have served as change agents responding to providers' needs. Utilizing their strengths, the RECs have developed tailored services to address the needs of providers. The main types of activities undertaken by RECs were customized to address the barriers and local market conditions of their target providers in three main domains: technical, organizational, and economical. RECs engage in core activities (EHR implementation, health information exchange, patient and family engagement, privacy and security, EHR optimization to achieve meaningful use) as required by the program, but methods utilized vary to meet local market or individual provider needs.

DRAFT

[11] https://www.healthit.gov/providers-professionals/regional-extension-centers-recs

B. The Use of Standards in Health Information Technology Procurement

As in the previous section, embedding in State MCO procurement requirements, the use of HIT and HIE can serve as significant tool for supporting State oversight and reporting on the quality of care to Medicaid beneficiaries in a managed care delivery system as part of both the State quality strategies and external quality review. MCO contracting can also be used as an impetus to promote provider adoption of ONC Certified Health IT. The 2014 ONC certification is applicable in calendar years 2016 and 2017 and 2015 ONC certifications for calendar year 2018.

4. *As applicable, is the State Medicaid Agency (SMA) directly promoting the use of federally certified health IT with providers through some mechanism or indirectly through provider network requirements in managed care contracts?*

   Background:
   "As the nation's largest purchaser of health care, the federal government can exercise considerable leverage across the care delivery system by linking payment with the use of electronic health information exchange and certified health IT. As described in the 2013 statement, "Principles and Strategy for Accelerating Health Information Exchange," HHS is committed to a natural lifecycle of policies to drive interoperability beginning with incentives, followed by payment adjustments and then conditions of participation in Medicare and Medicaid programs."[12]

5. Is the State leveraging and advancing federally established health IT standards throughout State funded programs, procurements and IT systems?
   a. Specifically, is the state advancing federal standards as stated in both 45 CFR 170.207 - Vocabulary Standards for Representing Electronic Health Information and the ONC Interoperable Standards Advisory?

   Background:
   "Standards and methods for achieving interoperability must be accessible nationwide and capable of handling significant and growing volumes of electronic health information, to ensure no one is left on the wrong side of the digital divide."[13] Nationwide interoperability across a diverse health IT ecosystem requires that all stakeholders agree to follow a common set of standards. "While each electronic health information sharing arrangement may continue to use its own policies, service agreements and technical standards to support participant priorities and needs, a common set of policies and technical standards must be adopted across the ecosystem to bridge disparate arrangements and support nationwide interoperability."[14] "The Interoperability Standards Advisory (ISA) process represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and determination of the "best available" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs." [15]

---

[12] "The Roadmap" – pg.2.
[13] "The Roadmap" – pg. xiv.
[14] "The Roadmap" – pg. 7.

[15] The Office on the National Coordinator for Health IT, "2016 The Interoperability Standards Advisory", pg.5. https://www.healthit.gov/standards-advisory/2016

The Interoperability Standards Advisory (ISA[16]) represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) coordinates the identification, assessment, and determination of the best available interoperability standards and implementation specifications for industry use toward specific health care purposes. The 2016 ISA's scope focuses on clinical health information technology (IT) interoperability.

If all States used the ISA in developing and implementing State policies and in applicable State procurements, significant advancements could be achieved in advancing the vision of Health IT interoperability across the care continuum. Health IT interoperability issues reflected on and funded through this DSRIP Waiver should use the best available standards referenced in the ISA.

Additionally, Medicaid Information Technology Architecture (MITA) emphasizes the importance of interoperability and industry standards. States should take an aggressive approach to HIE and interoperability governance for purposes of supporting interoperability while focusing on security and standards to keep interphase costs to a minimum. The CMS final rule published on December 3, 2015, "Mechanized Claims Processing & Info Retrieval Systems" requires in §433.112 a new focus on industry standards in MITA that support more efficient, standards based information exchange as described in 45 CFR Part 170. Specifically, 45 CFR Part 170 defines the common Meaningful Use data set, transport standards, functional standards, content exchange standards and implementation specifications for exchanging electronic health information, and vocabulary standards for representing electronic health information.

DRAFT

[16] https://www.healthit.gov/standards-advisory/2016

C. Leveraging the State Health IT Ecosystem

In order to leverage existing capabilities, CMS encourages states developing health information technology (health IT) strategies for a particular Medicaid program (i.e. Health Homes/ACOs/ 1115s/HCBS/LTSS) to gain a complete understanding of the state's overall health IT landscape and strategy. Below is a list of activities that may have been conducted or are currently underway in your state. CMS suggests state Medicaid program staff work closely with groups within their state to determine how this work might inform the Health IT requirements for the specific program under consideration.

6. *Is the State leveraging the insights gained from the MITA State self-assessment (SSA) or the State Medicaid Health IT Plan (SMHP) in the program design of this 1115 Demonstration ?*

   Background:
   A State can look to its MITA State Self-Assessment or State Medicaid Health IT Plan for a completed assessment of the health IT requirements and infrastructure within the State and provider communities necessary to support delivery system and payment reform.

   The purpose of conducting the SS-A is to identify the as-Is operations and To-Be environment of business, information, and technical capabilities of the State Medicaid Enterprise. Using standard methodologies and tools to document the way a state conducts business now, and intends to conduct business in the future, the SS-A facilitates alignment of the State Medicaid Enterprise to MITA Business, Information, and Technical Architectures (BA,IA, and TA), as well as the Enhanced Funding Requirements: Seven Conditions and Standards (Seven Standards and Conditions). The SS-A will:

   - Provide a structured method for documenting and analyzing a state's current Medicaid business enterprise.
   - Provide a structured method for documenting and analyzing a state's current Medicaid business enterprise.
   - Align SMA business areas to MITA business areas and business processes.
   - Enable the SMA to use defined levels of business maturity to help shape the future vision of its State Medicaid Enterprise.
   - Provide the foundation for a gap analysis that will support the state's transition planning.
   - Facilitate the MITA Maturity Model Roadmap (MITA Roadmap)
   - Focus the APD to reflect current project funding requests and identify what is achievable.

   The SMHP provides State Medicaid Agencies (SMAs) and CMS with a common understanding of the activities the SMA will be engaged in over the next 5 years relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA). CMS expects that the SMHP will contain at least four components: a current landscape assessment, a vision of the State's HIT future, specific actions necessary to implement the incentive payments program, and a HIT road map.

DRAFT

A State can look to its MITA State Self-Assessment or State Medicaid Health IT Plan for a completed assessment of the health IT requirements and infrastructure within the State and provider communities necessary to support delivery system and payment reform.

MITA State Self-Assessment (S-SA)

CMS requires States to complete an annual State Self-Assessment (S-SA), submitting a MITA five year roadmap for maturity progression, and implementing practices and procedures for system development phases. The current version is 3.0. A State's MITA plan describes the current capabilities of the State's Medicaid infrastructure and may describe the State's data sharing efforts, how clinical and claims data is integrated, interoperability between the State and other agencies/providers, capacity for care management, ability to promote secure data exchange and other State level capabilities that may be applicable to specific Medicaid programs. There is also an adaptation of MITA for Behavioral Health activities that CMS and SAMSHA collaborated on which States may have utilized.

State Medicaid Health IT Plan (SMHP)

The SMHP is an environmental scan and assessment that assesses the current status of EHR adoption by practitioners and hospitals and also describes goals for the future. Other aspects of Health IT are also assessed such as HIEs, cross border activities and interoperability with State public registries and databases. States may receive 90% FFP HIT administrative match for pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information.

7. *Is the 1115 Demonstration building on the health IT infrastructure that supports other Medicaid programs or CMS funded APDs to advance delivery system and payment reform?*

   Background:
   A proposed 1115 Waiver should build on and leverage other Medicaid and CMS program initiatives and be in alignment with the health IT that is needed more broadly within your state for delivery system reform. The principle idea is to ensure that the State is aligning and/ or building off of other federally funded initiatives such as State Innovation Model grants, Medicaid Innovation Accelerator program, Health Home State Plan Amendments, and to the extent that Medicaid providers are also Medicare providers, the Medicare Bundled Payment for Care Improvement Models and Medicare Joint Replacement model.

   Program designs should clearly indicate whether the State has the health IT infrastructure to promote and sustain delivery system and payment reform. And if not, State should clearly address how it will develop and fund it.

   A State can use its MITA State Self-Assessment (SS-A) or State Medicaid Health IT Plan (SMHP) for an assessment of the health IT assets and infrastructure requirements within the State and provider communities necessary to support delivery system and payment reform.

   These assessments can provide States a better understanding of health IT penetration and provider EHR adoption. Additionally, MCO contract requirements could be used to flow down health IT adoption requirements.

States need to understand what infrastructure exists within the provider communities and at the State level. Developing out the data sharing capacities amongst a community of providers ranging from hospitals, health homes, SNF, FQHCS, behavioral health providers, home care agencies and other key stakeholders is critical.

DRAFT

D. Accountable Oversight and Rules of Engagement for Health IT and Health Information Exchange (a.k.a. Governance)

Background - Every state is at a different level with regards to the maturity of its shared decision making, rules of engagement and accountability, also known as 'governance'[17] activities. Nationwide interoperability across the diverse health IT ecosystem will require stakeholders to agree to and follow a common set of standards, services, policies and practices that facilitate the appropriate exchange and use of health information nationwide and do not limit competition. Once established, maintaining interoperability will also require ongoing coordination and collaborative decision-making about future change.

To expand interoperable health IT and users to improve health and lower costs, States are being called[18] to integrate across all their CMS program and activities to ultimately realize multi-payer alignment. As discussed in the Nationwide Interoperability Roadmap [19], outside of the State's exchange and oversight role, States have had success in driving interoperability and data sharing through state activities related to multi-payer alignment as part of delivery system reform efforts.

8. **What is the state's role in health IT/HIE governance?**
    - *a.* Is there a shared vision across multiple payers around the health care system goals? What governance activities are currently taking place in your state?
        - i. Is there a plan to develop the governance of data exchange and use among payer and provider? If not a plan, can the state describe its current stakeholder situation and the key considerations related to such governance?
    - *b.* Does your state have a single or multiple governance structures? What is the state's role in these governance activities? What is Medicaid's role in this?
    - *c.* Does the State have a policy or practice to assist providers in joining a "trust" community to facilitate the appropriate secure exchange of health information for improved information sharing and patient centered outcomes?
    - *d.* Does the State have a strategy and plan to address the legal, policy, and technical barriers that inhibit health information exchange between entities within a state?
    - *e.* Is the State funding community-based organizations to implement point-to-point directed exchange or multi-site query-based health information exchange (HIE)?
    - *f.* Is the State helping providers share health information with each other through a health information exchange, clinical data repository, case management tool or some other means?

---

[17] "Establishing a common set of standards, services, policies and practices [for health information technology interoperability] is best accomplished through an inclusive and transparent process that sets priorities, makes decisions, establishes authorities and rules of engagement and ensures accountability. This activity is often referred to as 'governance.' Governance processes also help establish trust between disparate data trading partners and build confidence in the practices of the other people or organizations with whom electronic health information is shared." ONC Shared Nationwide Interoperability Roadmap, p.4.

[18] "Call to action: States should implement models for multi-payer payment and health care delivery system reform." The Nationwide Interoperability Roadmap Pg 44

[19] The Nationwide Interoperability Roadmap can be found at : https://www.healthit.gov/policy-researchers-implementers/interoperability.

States are transitioning to new payment and delivery system models. These new models require new health IT use cases that require governance approaches covering new data sources and users. These trust networks must support additional patient populations and community settings. This paradigm requires seamless and efficient information sharing. Governance activities can start off focusing on care coordination and delivery across organizations and grow to cover more complex use cases, ultimately resulting in data sharing, service and care coordination across sectors.

Governance initiatives exist because of the challenges associated with connecting sets of information in a way that supports business and program requirements. In these situations data governance activities bring different stakeholders together to figure out the legal, quality and technology standards required to enable the smooth flow of high quality dependable data between and amongst trading partners. This is the focus of governance that we will be exploring.

a. Is there a shared vision across multiple payers around the health care system goals? What governance activities are currently taking place in your state?

i. Is there a plan to develop the governance of data exchange and use among payer and provider? If not a plan, can the state describe its current stakeholder situation and the key considerations related to such governance?

The answer to this question drives all that is possible for achieving multi-payer payment transformation and for developing the modular health IT functions needed to support that transformation. For SIM states, this shared vision was articulated in award applications and would be incorporated into their Operational Plans (for test states) or their State Health Innovation Plans (for design states). Non-SIM states may have achieved this shared vision via other means.

The next question that naturally follows from that shared vision is this: Is there a plan to develop the governance of data exchange and use among payer and provider? In other words, it is important to understand the health IT and HIE governance activities that are currently taking place in your state. States can have multiple governance arrangements. These arrangements can include: a fully centralized State's HIE infrastructure, multiple local HIEs, a centralized HIE with HUB like translation services, or network of networks. Understanding the landscape in your state is critical to understanding the next two questions:

b. Does your state have a single or multiple governance structures? What is the state's role in these governance activities? What is Medicaid's role in this?

Whether the state leads the discussion or is just a participant in the discussion with other payers and providers, the state has a critical role in advancing and shaping the legal, technical and business incentives to ensure the flow of clinical and information across providers and the sustainability of HIE activities within the state. Ensuring providers within Medicaid are able to effectively share information with each other and between payers (i.e. Medicaid providers with Medicare Providers,

with other MCOs or ACOs) is essential to improve the quality of care and reduce costs within the healthcare system.

It is important to know if the State's role as it is currently being operationalized is larger than Medicaid's role in health information exchange. The demonstration should build on the larger state role and advance Medicaid's role.

c. Does the State have a policy or practice to assist providers in joining a "trust" community to facilitate the appropriate secure exchange of health information for improved information sharing and patient centered outcomes?

Enabling electronic health information exchange (HIE) requires consensus among multiple stakeholders. Often, complex technical and policy choices are required and, ultimately, a governance structure is established to provide oversight and to hold accountable the parties responsible for exchanging electronic health information. Another term for a governance structure is a "trust community." Trust communities often only support interoperability based on a particular technology or are focused on a specific use case. Trust communities can be regional or national in scope. Assisting or requiring providers to join a trust community can promote information sharing amongst clinical providers. This can complement the governance arrangements for sharing information to enable quality measurement in support of value-based payment.

States can be prescriptive concerning the trust communities that providers must join. While these trust communities are important and based on specific use cases such as care coordination, governance at the state level is also about operationalizing this trust to go beyond these discrete use cases to a more robust interoperable health IT eco-system that is ultimately about multi-payer alignment.

A number of electronic health information sharing arrangements, such as health information exchanges (HIE), networks and trust communities currently exist. These communities enable information exchange and are usually focused on specific use cases such as care coordination.

Examples of National and Regional Trust Communities

The DirectTrust Project – https://www.directtrust.org/

The Sequoia Project - http://sequoiaproject.org/

NATE – http://www.natex.org/site/1/Home

SHIEC – http://strategichie.com/

d. Does the State have a strategy and plan to address the legal, policy, and technical barriers that inhibit health information exchange between entities within a state?

The larger issue of the Medicaid Agency supporting and operationalizing overall "trust" amongst partners is also critical. That is promoting electronic health information

sharing arrangements that can be leveraged to enable interoperability between otherwise unaffiliated organizations or parties.[20]

e. Is the State funding community-based organizations to implement point-to-point directed exchange or multi-site query-based health information exchange (HIE)?

   As mentioned in question 2 of this document, the State Medicaid Director Letter #16-003 "RE: Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers" can fund HIE onboarding for all Medicaid providers as long as there is reasonable justification that this supports an eligible MU provider for attestation. Whether through an APD or the 1115 Demonstration, states can support community-based organizations to implement point-to-point directed exchange or multi-site query-based health information exchange (HIE).

f. Is the State helping providers share health information with each other through a health information exchange, clinical data repository, case management tool or some other means?

   The questions in this section focus on ways a State Medicaid Agency through the design of an 1115 demonstration can support providers to share patient clinical and payer claims information between providers. For example multiple 1115 demonstrations are focused on creating integrated networks of providers to support patient centered care and reduce costs. When there are multiple integrated delivery networks or accountable care organizations being funded through an 1115 demonstration it is critical to ensure that the governance structures in place ensure interoperability not only within a provider grouping but between the providers groups. There are many ways this can be approached. This includes requiring: one case management tool be used across groups, one common set of standards for data capture, onboarding onto a state's HIE, interoperability with a clinical data repository, use of the same data standards and or ensuring all provider groupings have a compatible or mutually reinforcing governance structure.

9. Ultimately, delivery system reform demands robust and comprehensive governance approaches at the state level that would allow for the collection, synthesis, and use of both clinical and claims information.
   a. How is the State analyzing the data it is collecting to advance the three part aim: improved care for the individual, lower costs and improved population health outcomes?
   b. What is the State considering or, if further developed, what are the state's plans for enabling the, collection, synthesis and use of both claims and clinical information?

[20] See Interoperability Roadmap for more details on page 4. https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf

Governance allows a state to effectively collect clinical and claims information. Data is one of the most valuable assets and longest living, in any organization, especially healthcare as we transition into a more analytically driven industry.

Background:
The Roadmap directly ties date analyses with governance activities tied to electronic health information and interoperability.
"ONC and stakeholders participating in the shared decision-making process, human service providers and health-related device overseers should define standards, services, policies and practices for interoperability of clinical electronic health information to support research and big data analyses and electronic health information…"[21]

DRAFT

[21] "The Roadmap" – pg. 54.

E. Advancing use of Health IT to Support Quality Measurement

Almost by definition, quality measurement and value based payments are integral to delivery system reform and incentive payment programs. Ensuring health IT is leveraging state and provider health IT assets (e.g. provider health IT infrastructure and reporting acquired through EHR Incentive Program) is critical for advancing the transformation of our nation's Medicaid health care enterprise from volume based payments to value based payments.

10. *Is the State leveraging any of the CMS electronically specified clinical quality measures (eCQMS) as part of the 1115 Waiver quality strategy?*

Background - With over $10B in payments made to Medicaid providers through the MU EHR Incentive Program over the last five years, a significant provider based health IT infrastructure has been created within states. Leveraging the e-CQM MU requirements already advanced through this health IT infrastructure is a clear way to accelerate advancement of DSR and value based payments.

States have the option of receiving eCQMs for eligible providers (EPs) and eligible hospitals (EHs) in Stage 2 of the Medicaid EHR Incentives Program. Included as part of the Stage 3 rules, CMS requires that all States as part of their Medicaid EHR incentive program articulate within the State plan their strategy and plan for mecum reporting. HITECH 90-10 matching funds are permitted to develop relevant infrastructure such as a clinical data repository to receive reported eCQMs. Some alternative payment models such as the Comprehensive Primary Care Initiative and the Medicare Shared Savings Program include eCQMs in their design. The Medicare Access and CHIP Reauthorization Act reinforces the shift to eCQMs.

In order to allow participants to successfully report CQMs electronically, CMS is providing a set of electronic specifications for clinical quality measures (eCQMs) for EPs and EHs for use in the EHR Incentive program for electronic reporting. These electronic specifications contain multiple parts which allow certified EHR technology from which mecum data must be submitted to be programmed to accurately capture, calculate, and report clinical quality measures electronically. A concrete way to reinforce the adoption and use of eCQMs would be for a State to include them in a waiver as part of the quality strategy.

11. *Is the State using any of the CMS electronically specified clinical quality measures (eCQMS) as part of the 1115 Demonstration payment or reimbursement methodology?*

Background - "As described in the 2013 statement, "Principles and Strategy for Accelerating Health Information Exchange," HHS is committed to a natural lifecycle of policies to drive interoperability beginning with incentives, followed by payment adjustments and then conditions of participation in Medicare and Medicaid programs. For instance, HHS will explore opportunities to promote interoperability through increasing participation in value-based payment. In January 2015, HHS Secretary Burwell announced a set of delivery system reform goals to tie payment to how well providers care for their patients, instead of how much care they provide."[22]

[22] "The Roadmap"- pg. 2

Additionally, the State could tie eCQMs reporting to cost savings calculations and payment reform. When appropriate, Health IT could be used to document cost savings. Part of the logic behind this is that to the extent to which Health IT is used to document reporting of 'shared savings', the same Health IT could be used to document cost savings.

12. *Is the State leveraging already established "data standards" for quality measure reporting requirements?*

Background: States could establish standards that accomplish uniform provider reporting of all the measures using existing EHR ECQM standards for specification and reporting. Measuring and reporting eCQMs can help ensure that a State's health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care. Reinforcing adoption of eCQMs and the infrastructure used to support them throughout the health care enterprise can have far reaching consequences and positively impact the system. Planning for and implementing eCQMs, including the reporting of standardized eCQMs documented by an individual's QRDA-1 document [23] will prepare providers and the Medicaid system for the adoption and use of these measures across programs. A concrete way to reinforce this would be for a State to include and repurpose MU eCQMs in their 1115 waiver and or as part of their quality strategy.

Additionally, a State could assist and promote electronic reporting (i.e. using QRDA, CCD etc…) of quality measures that are standardized and automated and not based on manual chart or report abstractions. An outcome of this could be the comparability of multiple practice models. For example QRDA standardized measurement for "controlling hypertension" for a PCMH program could then be comparable against other practice models. To understand the effectiveness of a group in controlling hypertension, the State and the federal government should be able to do a hospital to hospital, or provider to provider comparison. The understanding and measurement criteria for hypertension control should be the same and it should not matter whether the hypertension reporting is coming out of a health home, hospital or PCMH.

DRAFT

[23] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

F. Identity Management, Provider Directories, and Attribution

Identity management and provider directories are two of several modular functions that are essential elements of a health IT infrastructure to support value-based payment. The information contained in these two modular functions is essential for properly attributing patients (individuals) to providers for measuring value. The steps involved in attribution require a robust state-based identity management function as well as robust provider directories necessary to link cost and quality information to a specific provider or group of providers. Attribution can be used to enhance connectivity.

13. *Does the State have a functioning identity management capability to identify individuals within their Medicaid enterprise? E.g. Is the State able to link individuals to providers and how does the State share these relationships with providers and their networks (i.e. how does the state plan to perform electronic attribution of people to providers?)*

At the State, MCO/ACO Delivery System and Provider level, the State should ensure it has a clear path forward for implementing a strategy for patient attribution and identity management coupled with using a master patient index and provider directory.

Background:
"Verifiable Identity and Authentication of All Participants"[24] are critical pieces to effectively linking individuals with providers, engage in attribution and to ultimately support value based payments. Provider Directories were discussed in an ONC workshop held in April 2016. Resources from that workshop including work being done by the States of Oregon and Rhode Island to advance state wide provider directories are useful to understanding the current state of creating state wide "provider directory/(ies)" and real-life state considerations.[25]

Identity Management

Whether it is in coordinating benefits or getting a complete picture of actual services and costs associated with an individual, a strong identity management strategy is a pre-requisite. When patient A goes to a provider, it is important for that provider to be able to query a system for any other records associated with that patient from other providers for test results and or medical history. It is estimated that 1 in 3 consumers are burdened with providing their own health information when seeking care for a medical problem (such as test results or medical history). For example, to calculate avoidable hospitalizations, the State would need to know whether John Doe who had a surgery it Hospital 1 is the same person as John D Doe who goes to Hospital 2 for surgery related complications. Having a clearly articulated identity management policy and goal is important and it is important at the State, provider and beneficiary level. Unfortunately, neither the provider nor the individual can affect this kind of change. It can only happen with strong State policy and commitment and multi-payer stakeholder buy-in.

Master Patient Index

A master patient index (MPI) is an electronic medical database that holds information on every patient registered at a healthcare organization. It may also include data on physicians, other medical staff and facility employees.

[24] "The Roadmap"- pg.11.
[25] https://confluence.oncprojectracking.org/display/PDW/Workshop+Documents

Provider Directory

Provider directories are important to advance improved population health. With a complete provider directory at the plan level, beneficiaries will have a complete listing and all available choices to be able to look up available providers in their area. It would also provide a data model with standards that HIEs and EHRs can adopt to enable query and response for electronic service information including electronic address, with corollary benefits. That is it will facilitate standardization and simplification of EHR implementations of interfaces to query Provider Directories for electronic service information including electronic addresses and Certificate Directories for digital certificates. Finally, e-referrals can be more accurate.

Provider directories are important tools in supporting many different functions of Medicaid. This begins with certain fundamental tasks, but also includes facilitating electronic exchange of information and supporting activities necessary for delivery system reform.

The fundamental tasks include enrolling and tracking providers, facilitating administrative claims transactions, and publishing a list of eligible providers. With a complete provider directory at the plan level, providers and beneficiaries will have a complete listing of all available providers in their area.

However, this rich data source can be used to facilitate many electronic activities. This includes using the directories to store secure email (e.g., Direct) addresses and share those addresses, facilitating care coordination. If this provider directory is created in a standardized manner, then it can interact with other directories, sharing information or even allowing for the systems to update one another with the most current information. Making such systems standardized can also mean that software designers can create apps that plug into the State's systems, making the data available to consumers in ways that they find most useful.

Provider directories are critical tools for States implementing delivery system and payment reforms. This is because provider directories facilitate determination of accountability for payment and attribution of quality performance. A provider directory might not determine who is accountable, but might support that effort. It can track organizational affiliations, which is often a complex many-to-many relationship. A provider directory can determine which provider/organization receives reporting and population-level analytics/decision support.

How States go about determining their strategy for fully harnessing the power of provider directories will vary. Within State government, there are often multiple provider directories, serving multiple use cases. Outside of State government, there will be many provider directories in use by private sector entities in different ways. The challenge and opportunity is for the State to develop a provider directory strategy that prioritizes needs and creates value through alignment between different technologies, policies, business processes, and governance activities.

A key consideration is whether the State has access to a consolidated Provider Directory accessible by stakeholders, including providers, private purchasers, etc.?

DRAFT

G. Service Delivery

14. *Is health IT being used to improve services being delivered, such as through a PCMH, Traditional FFS, MCOs, ACOs, and/or tele-health model?*

Background - From improved care coordination to e-referrals there are many different health IT considerations as States consider how services are being delivered. States should consider the following high level considerations: governance, financing, business operations, policy/legal implications, security mechanisms, consent management, identity management, data transport, patient attribution, and data quality and provenance.26

Care Coordination

Often times a waiver may explicitly indicate that a goal of the 1115 could be to ensure the coordination of and continuity of health care delivery to patients moving from inpatient (hospital) to outpatient (ambulatory care settings). In these cases improved care coordination could be to look at the State's strategy to promote the use of ONC Certified health IT technologies within the provider community as part of this Waiver for both eligible MU and ineligible MU providers? Another heath IT aspect of care coordination could be looking at medication reconciliation, and the use of an e-standard between participating providers for transitions of care as promulgated through the ONC Interoperability Standards Advisory.

It would be Can the State articulate its strategy to ensure providers are able to delivery care as envisioned through the care delivery redesign, including promoting and funding providers for health IT, such as EHRs and connectivity to HIEs?

e-Referrals

E-referrals or electronic referrals are electronic platform that enables the seamless transfer of patient information from a primary to a secondary treating provider through the use of a practitioner's client management system. Ensuring provider adoption of health IT to facilitate the sending and receiving of the referral, and data standards for the referral are important considerations to successfully implement e-referrals.

Telehealth

Telehealth can be defined as use of broad array of technologies to provide medical health, and education services between places of lesser and greater medical capability and/or expertise, for the purpose of evaluation, treatment, and training[27].Medical data exchanged may be in the form of multiple formats: text, graphics, still images, audio and video. The Clinical information or data exchanged may occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through "store and forward" applications.

Health IT considerations for a State when developing and implementing a Telehealth program include: governance, financing, business operations, policy/legal implications, security mechanisms, consent management, identity management, data transport, patient attribution, and data quality and provenance.

---

[26] See ONC SIM Resource Center for learning guides and policy guidance on each of these areas. https://www.healthit.gov/providers-professionals/state-innovation-model-health-it-resource-center

[27] http://cchpca.org/what-is-telehealth

Appendix A - Column Title with Brief Description

This Appendix provides an explanation of each of the columns in the accompanying Excel Spreadsheet that States could use to document responses to key Health IT questions.

Column Title – Brief Description

1) 1115 Waiver Topic Area – The topic areas identified within the application for targeted health IT considerations include: Background, Governance, Program Description, Provider Qualifications, and Quality.
2) Location within 1115 Application – This column can be used to identify areas within the 1115 application where the waiver topic area could be found.
3) 1115 Application Waiver Component – This column identifies the 11115 waiver application component where the topic area could be found.
4) 1115 Waiver Element – The 1115 Waiver Elements identified within the application for targeted health IT considerations include the following: eligibility, financial and quality oversight, overarching considerations, service delivery, payment methodology and reimbursement, and leveraging ONC certified health IT.
5) Question – This column identifies the health IT question associated with the topic area that State's should consider as the application is being developed.
6) Four Actors - Please consider the Health IT implications at the State, MCO/ACO, provider and beneficiary level. Please consider how the question is addressed within each topic area. Provided within each topic section are areas to consider and/or illustrative questions.
7) Addressed State (Y/N)? MCO/ACO (Y/N)? Provider (Y/N)? Beneficiary (Y/N)? – Please include whether the health IT question has been addressed at each of the four levels. If "Y" or "N/A" then there is nothing else required. If "N", please use column 8 and column 9 (column 8 – Action Steps by Appropriate Level, column 9- Estimated Date to be Completed) to identify the action steps required to be accomplished by the State to complete with estimated completion dates for each milestone.
8) Action Steps by Appropriate Level – If column 7 (Addressed by all actors) includes any Health IT implications not fully addressed by any actor, please use this to document high level action steps that the State can take.
9) Estimated Date To be Completed – Please use this column to identify estimate completion dates for each milestone listed in previous column (8 – Action Steps by Appropriate Level).

DRAFT

Appendix B - Key Questions

Promoting and Funding Provider Health IT Adoption and Use

1. Does the demonstration provide direct provider incentives for EHR adoption or indirectly through MCO contract requirements (either incentives or qualification/participation standards)?
2. Does the State support EHR adoption or HIE onboarding for ACOs, MCOs, LTSS providers, EPs, and other ineligible MU providers? Does the SMA help Medicaid providers eligible for the EHR incentive programs but not yet enrolled have the health IT they need to share information with other providers? How?
    a. Do the activities described in the SMHP to help incentive eligible providers also support the 1115 efforts described here?
3. Is the State providing technical assistance to support health information technology adoption amongst providers?

The Use of Standards in Health Information Technology Procurement

4. As applicable, is the SMA directly promoting the use of federally certified health IT with providers through some mechanism or indirectly through provider network requirements in managed care contracts?
5. Is the State leveraging and advancing federally established health IT standards throughout State funded programs, procurements and IT systems?
    b. Specifically, is the state advancing federal standards as stated in both 45 CFR 170.207 - Vocabulary Standards for Representing Electronic Health Information and the ONC Interoperable Standards Advisory?

Leveraging the State Health IT Ecosystem

6. Is the State leveraging the insights gained from the MITA State self-assessment (SSA) or the State Medicaid Health IT Plan (SMHP) in the program design of this 1115 Demonstration ?
7. Is the 1115 Demonstration building on the health IT infrastructure that supports other Medicaid programs or CMS funded APDs to advance delivery system and payment reform?

Accountable Oversight and Rules of Engagement for Health IT and Health Information Exchange (a.k.a. Governance)

8. What is the state's role in health IT/HIE governance?
    a. Is there a shared vision across multiple payers around the health care system goals? What governance activities are currently taking place in your state?
        i. Is there a plan to develop the governance of data exchange and use among payer and provider? If not a plan, can the state describe its current stakeholder situation and the key considerations related to such governance?
    b. Does your State have a single or multiple governance structures? What is the State's role in these governance activities? What is Medicaid's role in this?
    c. Does the State have a policy or practice to assist providers in joining a "trust" community to facilitate the appropriate secure exchange of health information for improved information sharing and patient centered outcomes?
    d. Does the State have a strategy and plan to address the legal, policy, and technical barriers that inhibit health information exchange between entities within a state?
    e. Is the State funding community-based organizations to implement point-to-point directed exchange or multi-site query-based health information exchange (HIE)?
    f. Is the State helping providers share health information with each other through a health information exchange, clinical data repository, case management tool or some other means?

DRAFT

9. Ultimately, delivery system reform demands robust and comprehensive governance approaches at the state level that would allow for the collection, synthesis, and use of both clinical and claims information.
    a. How is the State analyzing the data it is collecting to advance the three part aim: improved care for the individual, lower costs and improved population health outcomes?
    b. What is the State considering or, if further developed, what are the state's plans for enabling the, collection, synthesis and use of both claims and clinical information?

Advancing Use of Health IT to Support Quality Measurement

10. Is the State leveraging any of the CMS electronically specified clinical quality measures (eCQMS) as part of the 1115 Demonstration quality strategy?
11. Is the State using any of the CMS electronically specified clinical quality measures (eCQMS) as part of the 1115 Demonstration payment or reimbursement methodology?
12. Is the State leveraging already established data standards for quality measure reporting requirements?

Identity Management, Provider Directories and Attribution

13. Does the State have a strategy for accurately identifying individuals within their Medicaid enterprise? Does the state have a shared, state-wide strategy for consistently identifying individuals across payers and providers? E.g., is the State able to link individuals to providers and how does the State share these relationships with providers and their networks (i.e. how does the state plan to perform electronic attribution of people to providers?)

Health IT and Service Delivery

14. Is health IT being used to improve services being delivered, such as through a PCMH, Traditional FFS, MCOs, ACOs, and/or tele-health model?

DRAFT

Appendix C – Health IT Draft Special Terms and Conditions

Special Terms and Conditions – Draft Language could be included in an 1115 demonstration

HEALTH INFORMATION TECHNOLOGY.
Health Information Technology (Health IT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a) Health IT: The State must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.
b) The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing HIE infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.
c) The State will use the standards identified in the 'Interoperability Standards Advisory– Best Available Standards and Implementation Specifications' (ISA) (i.e. provider directory, Care Plan Standards, ADT Messaging, Clinical Decision Support, Quality Reporting, etc…) which are published annually by ONC and 45 CFR Part 170 Subpart C in developing and implementing State policies, in advancing standards and in all applicable State procurements (i.e. including managed care contracts).
d) Care Plan information will be shared electronically with all members of the provider team. If this is not possible at the inception of the demonstration, the state will develop a clear plan to achieve this goal within 120 days of application approval.
e) To ensure an accurate picture of all services provided to an individual, the State will ensure a robust identity management system. If this is not possible at the inception of the waiver, the state will develop a clear plan to achieve this goal within 120 days of application approval.
f) The State will ensure that an accurate and complete (> 95%) provider directory (directories) is (are) maintained. This could be measured by NPI information collected through claims in rendering and referring provider. If this is not possible at the inception of the waiver, the state will develop a clear plan to achieve this goal within 120 days of application approval.
g) The State will ensure improved coordination and improved integration between Behavioral Health, Physical Health, Home and Community Based Providers and community level collaborators for Improved Care Coordination (as applicable) through the adoption of provider level Health IT infrastructure and software to facilitate and

DRAFT

improve Integration and Coordination. The state will develop a clear plan to achieve this goal within 120 days of application approval.

h) The State will reinforce adoption of electronic Clinical Quality Measures (eCQMs) within the provider community and the infrastructure to support them.

i) The State will consider tying elements of e-CQM reporting to shared savings calculations and payment reform.

DRAFT