

# Addendum to State Health IT 1115 Toolkit – State Examples (V1.0)

---

This document is to be used in conjunction with the 1115 toolkit and provides actual state examples relating to each question identified in the 1115 Health IT Toolkit.

## 14 Key Questions with State Examples

### A. Promoting and Funding Provider Health IT Adoption and Use

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

#### **State Example associated with funding health IT infrastructure at the provider, MCO/ACO delivery system level.**

Arkansas - In 2013, the Health Care Independence Program 1115(a) Demonstration Waiver was approved by CMS.

The demonstration specifically requires the state to have a plan in place for provider Health IT adoption including 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.

In another Arkansas example, the State's Patient Centered Medical Home (PCMH) program requires PCMHs to have a 12 month plan to document investments in health care technology or tools that support practice transformation and to integrate EHRs into practice workflows.

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?*

#### **State Examples support EHR adoption and HIE infrastructure for ACOs, MCOs, LTSS providers**

Minnesota - 2015 Interoperable EHR Mandate - Minn. Stat. §62J.495 - Requires by January 1, 2015 for all hospitals and health care providers across the continuum of

healthcare to have an "interoperable electronic health records system." There must also be a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The mandate also requires providers to connect to a State-Certified health information organization either directly or through a connection facilitated by a State-Certified Health Data Intermediary as defined in section 62J.498.

Arkansas – 2016 PCMH program: Arkansas Payment Improvement Initiative provides access to reports through the AHIN portal for Patient-Centered Medical Home and Episodes of Care providers<sup>1</sup>. Additionally, the AR PCMH program requires PCMH connection to SHARE or another system that delivers hospital discharge information to practices within 48 hours of discharge. Finally, the EHR adoption requirements within the PCMH program stipulate that the EHR adopted by providers must be one that is certified by the Office of the National Coordinator (i.e. Certified EHR Technologies "CEHRT").

Iowa - Iowa implemented the Medicaid EHR Incentive Payment Program with a rollout date of January 3, 2011. The Iowa Medicaid Enterprise coordinated outreach efforts with the Regional Extension Center and Iowa Department of Public Health as well as the eHealth Advisory Council to assist eligible provider's and hospital's participation in the program. Iowa has made over \$118 M in Medicaid EHR incentive payments to Iowa providers and hospitals.

Arizona – A related example includes can be found under the ONC HIE Cooperative agreement Program: The Arizona Strategic Enterprise Technology Office (ASET) used grant funds to encourage HIE participation and care transformation through the Unconnected Providers Program, focusing on those not eligible for the EHR Incentive Program (e.g., Long-term and Behavioral health). ASET created a second grant program to accelerate HIE for health care organizations and payers that were working to make clinical data more available to their providers. The grant supported organizations that were creating, developing, or maturing their IT environment to increase data exchange to adapt to change in reimbursement methods or to help providers meet meaningful use requirements.

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. The AHCCCS Program was awarded in April 2015 a CMS State Innovation Model (SIM) Planning Grant that will address improving care coordination through health IT for behavioral health and physical health integration, correctional health, and American Indian Health Population health.

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

### **State Example associated with State Led Provider Supports for Health IT Adoption**

---

<sup>1</sup> (<https://www.medicaid.state.ar.us/Provider/docs/pcmh.aspx>)

California - Recently, DHCS implemented the California Technical Assistance Program (CTAP), modeled after the Office of the National Coordinators Regional Extension Center (REC) Program. The CTAP will assist eligible professionals and their practice groups in adopting and implementing EHRs as well as achieving meaningful use (MU). CA's DHCS will encourage eligible home health providers to avail themselves of these free services, which include educational outreach, project management for EHR adoption, implementation and support in achieving MU, workflow redesign, and assistance connecting to health information exchange services.

## **B. 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?*

### **State Examples including the use of ONC Certified Health IT requirements in provider network contracts**

Iowa - Iowa has established ACO agreements to manage the new Iowa Wellness Plan population as of January 1, 2014. Medicaid has 5 ACO agreements in place with major healthcare system and as noted above. ACOs must have a participating agreement with the IHIN, must use HIT to securely exchange information and participate in the exchange of ADT data.

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?

### **State Examples advancing the use of a Standard Identified in the 2016 Interoperability Standards Advisory**

New York – NY's 1115 DSRIP includes the use of "care plan" standards based on the "ISA". Standards are adopted as they are part of the provider participation requirements.

Massachusetts - Chapter 224 of the Acts of 2012 (Ch. 224), the Massachusetts legislature enacted two significant provisions related to EHR use and HIE use. First, as a condition of medical licensure, applicants must "demonstrate the skills to comply with the 'meaningful use' requirements, as set forth in 45 C.F.R. Part 170" (1). Second, all providers in the State (not just physicians and hospitals), "All providers in the commonwealth shall implement fully interoperable electronic health records systems that connect to the Statewide health information exchange" by January 1, 2017 (2).

In January 2015, the MA Board of Registration in Medicine published its final regulations on the "EHR Proficiency Requirement," stating that proficiency could be demonstrated via participation in the Meaningful Use program, employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program, by being a participant in the Massachusetts Health Information Highway, or completion of 3 CME hours on MU and eCQMs (3).

### C. Leveraging the State Health IT Ecosystem

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

#### **State Examples of use of the MITA State Self-Assessment and or State Medicaid Health IT Plan in Medicaid Program Design**

Michigan - the following was taken from the State's SMHP. Under the Trailblazers effort in 2013 MiHIN initiated the Clinical Quality Measure Recovery and Repository (CQMRR) project which started first accepting Quality Reporting Document Architecture (QRDA) Category 3 files and more recently began accepting QRDA Category 1 files in a DataMart for State Medicaid. MiHIN's capabilities for quality measure reporting are being expanded to include measures from CCDs and Supplemental Clinical Data Files (SCDFs) for conversion into NCQA XML for HEDIS. Later measure sets to be added will include QRS, Medicaid, and PQRS.

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?*

#### **State Examples of Building Medicaid Health IT Infrastructure from other Programs or APD funded Initiatives**

Washington's 1115 Demonstration— the Washington State 1115 program builds on the Washington State SIM grant and APD funded initiatives within the state.

### D. 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?

### **State Examples associated with Data Sharing and the Secure Exchange of Health Information amongst providers**

**New York** has a well-developed model for statewide HIT/HIE governance. They are going through a process to identify opportunities to tighten their governance structure.<sup>2</sup> Language: NYSDOH enters into a contract with the state designated entity that will govern the relationship between the department and the SDE and set minimum standards for the SDE and the QEs.

**Colorado** – Executive Order B 2015-008 (see attachment and [link https://drive.google.com/file/d/0BxUiTIOWSbPUN2NkMWZtOXRGUfU/view](https://drive.google.com/file/d/0BxUiTIOWSbPUN2NkMWZtOXRGUfU/view))

To promote the expanded use of Health IT in Colorado, the State will:

- 1) Establish an open and transparent statewide collaborative effort to develop common policies, procedures, and technical approaches that will enhance the state's health IT network;
- 2) Promote and advance data sharing by reducing or removing barriers to effective health information sharing;
- 3) Support health innovation and transformation by enhancing Colorado's health information infrastructure; and
- 4) Improve health in Colorado by promoting the meaningful use of Health IT.

**Pennsylvania** – “The purpose of the Pennsylvania eHealth Partnership Authority (the Authority) is to improve healthcare delivery and healthcare outcomes in Pennsylvania by enabling the secure exchange of health information (HIE). The Authority was created through unanimously-passed legislation (P.L. 1042) in July 2012. “Current state – The Governor [announced](#) in February 2016 the Authority will be pulled back into the state under Dept. of Human Services for improved efficiencies and money savings. This was part of the 2016-2017 budget.

---

<sup>2</sup> Their current regulation language can be found at: <https://regs.health.ny.gov/> and <https://regs.health.ny.gov/content/section-3002-establishing-shin-ny>.

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?

**State Example associated with business intelligence, data analytics and data management in general.**

Wyoming - Using Medicaid data and population health platform, the State of Wyoming and its contractor have been able to analyze patient information and effectively reduce the number of emergency room visits by patients using Medicaid. There are 88,000 Medicaid enrollees in Wyoming. The analytics program has been effective in reducing readmissions occurring within 30 days among this population from 7.4 percent in 2012 to just 6.89 percent a year later.

To reduce emergency room visits, the State IT vendor flagged the records of Medicaid patients who had been admitted to the emergency room more than 10 times in the previous year (according to Wyoming's Department of Health, 5 percent of Medicaid patients account for 54 percent of costs). These patients were then contacted by care managers in an effort to help them better manage their health after discharge.

As a result of this data-driven initiative, patients who would benefit from care managers were identified and, as a result, Wyoming has seen ER costs per member, per month decline by more than 20 percent.

## **E. 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 Waiver quality strategy?*

**State Examples Leveraging the use of eCQMS**

North Carolina - "Medicaid [has a] requirement for mecum reporting from providers" (Final Report) The N3CN Informatics Center (IC) has been designated as the vehicle for collecting Stage 2 Meaningful Use clinical quality measures for all professionals Statewide who are eligible for the NC Medicaid EHR Incentive Program. In letters dated December 27, 2010 and July 6, 2012, CMS approved the use of HITECH funds for expanding connectivity between providers and the N3CN IC and enhancing the IC's current capacity and functionalities to accommodate Stage 2 MU data collection and analytics. (IAPD)

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?*

## **State Examples advancing the use of eCQMS in payment and reimbursement**

Michigan - The State of Michigan has worked with MiHIN to create and test a mechanism for automated reporting of eCQMs to the State. This mechanism already works for reporting QRDA Category 1 and 3 files to MiHIN via multiple transport secure mechanisms including Direct Secure Messaging and Michigan's Health Information Exchanges connected via Virtual Private Networks. The State and MiHIN have also Stated the use of CCDs will be support as the quality payload mechanism for integrated care initiatives and ACOs. CQMs collected by MiHIN will be viewable by providers and payers via quality portals in the Statewide Health Provider Directory

Oregon - Oregon clinics may apply to be recognized as a Patient-Centered Primary Care Home (PCPCH). Clinics recognized through the PCPCH program have different levels (Tier 1, Tier 2, Tier 3, Tier 3 Star) according to the types of criteria met, with Tier 3 Star being the most advanced and meeting most criteria. PCPCH-recognized clinics may be eligible for incentive payments.

PCPCH measures for HIT/HIE include:

- Sharing clinical information electronically with other providers and care entities
- Meeting "Meaningful Use" standards with the electronic health record
- Being able to provide patients with their medical record electronically upon request

12. *Is the State leveraging already established data standards for quality measure reporting as a requirement?*

## **State Examples advancing the use of QRDA reporting**

Oregon – The State of Oregon requires all CCO “Coordinated Care Organizations” to export all quality metrics using the QRDA III Standard. “OHA’s intention is to leverage the ability of 2014 certified EHRs to submit clinical quality measure data in a standard format, known as Quality Reporting Data Architecture (QRDA) to the CQMR. Provider practices within a CCO network that have upgraded to 2014 certified EHR technology (CEHRT) should be able to export data as QRDA Category III (individual patient data aggregated at the provider level) and QRDA Category I (individual patient level data).”

- Taken From Oregon Health Authority CCO Incentive Metrics Guidance Documentation

## **F. Identity Management, Provider Directories, and Attribution**

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?)*

### **State Examples advancing the use of attribution**

New York – from the 1115 DSRIP Waiver

The State of New York is using an advanced methodology to assign individuals to a performing provider system. The Attribution methodology incentivized health IT uptake on providers to ensure ability to participate in a PPS. Two types of attribution were used: A4V (Attribution for Valuation) and A4P (Attribution for Performance)

- Attribution for Valuation: Creates a number of Medicaid and uninsured lives for use in the calculation of potential performance awards as part of the DSRIP valuation process

Goal: Attempts to align the value of potential performance awards with the depth, breadth and type of a given PPS network: the more lives covered by a PPS, the higher the potential valuation

- Attribution for Performance Measurement: For use in performance and outcome measurement

Goal: Defines the actual population of individuals a given PPS network is responsible for (based purely on PPS network loyalty irrespective of PPS type) when evaluating performance.

On April 5<sup>th</sup> and 6<sup>th</sup> 2016, ONC hosted a provider directory workshop. Two presentations from that workshop from the States of RI and OR can be found at the link below:

<https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/Workshop+Documents>.

“The Rhode Island Provider Directory Project: Creating a Centralized, Statewide Provider Directory” and “Flat File Directory for Direct Addresses and State-level Provider Directory” presentations and recordings can be accessed through the link.

#### *Rhode Island: The Solution*

By creating and maintaining a single authoritative, statewide provider directory, RIQI will meet its internal needs to accommodate patient control over who sees their data in Current Care. And, by making the data available to the other stakeholders in the state, RIQI is creating a product that supports its financial sustainability as well as reducing ineffective, duplicative efforts both within and across various parties in the health care system. The goal is to create a single source truth—which is accurate and up-to-date- and to deliver that benefit across the community.

#### *The Process*

RIQI will manage the provider directory much like the Health Information exchange, collecting and aggregating data across organizational boundaries to create a single longitudinal record for providers.

## 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?*

### **State Examples advancing health IT**

Michigan - Under the multi-payer reform initiatives demonstration program, funded by CMS, States are participating in initiatives to make advanced primary care practices more broadly available. The Michigan Primary Care Transformation (MiPCT) Project is a three-year, multi-payer, State-wide project aimed at reforming primary care payment models and expanding the capabilities of patient-centered medical homes (PCMH) throughout the State. The selection of Michigan as one of eight States in the Multi-Payer

Advanced Primary Care Practice Demonstration (MAPCP), sponsored by the Centers for Medicare and Medicaid (CMS), was the catalyst for bringing together Medicare, Michigan Medicaid Health Plans, Blue Cross Blue Shield of Michigan and Blue Care Network to improve upon the strong PCMH foundation in the State and create a uniform, sustainable primary care platform. Additional payers are expected to join as the project proceeds.

### **Examples of Telehealth at the State level**

Alaska – Alaska Medicaid funds Telehealth / telemedicine programs, live video reimbursement, as well as store and forward services.

Oregon - A portion of Oregon's State Innovation Model (SIM) grant is funding five Telehealth pilot programs to evaluate the feasibility of and increase the access to Telehealth in different patient populations and with Telehealth modalities across Oregon, with an emphasis on rural locations.