Health Information Technology and Health-Related Services

Background

Health-related services (HRS) began in 2013 with the inception of Oregon's Coordinated Care Organizations (CCOs). The history of HRS and how it has evolved is further detailed in the HRS Brief. HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One of the purposes of HRS is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health (SDOH), including the health-related social needs of their members.

For CCOs to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. For a full definition of HRS, CCOs should rely primarily on the OHA HRS Brief and Oregon Administrative Rules (OARs) 410-141-3500 and 410-141-3845. The Code of Federal Regulations (45 CFR 158.150 and 45 CFR 158.151) should be used for supplemental CCO guidance only.

The purpose of this HIT guidance is to define HRS and use of HRS for HIT in Oregon. Additional guidance and technical assistance around HRS can be found on OHA's HRS webpage.

Definitions

Health-related services (HRS): Non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. The two types of HRS include flexible services and community benefit initiatives, as defined below

Flexible services (FS): Cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being.

Community benefit initiatives (CBI): Community-level interventions that include — but are not limited to — OHP members and are focused on improving population health and health care quality.

Changes in this February 2024 release

An example of functions that support the provision of covered services was added to the list examples of required HIT efforts that are excluded from HRS on page 5.

Health information technology in Oregon

Oregon is transforming health care delivery to improve health outcomes and quality of care while reducing costs for all Oregonians. HIT is essential to these efforts. Timely access to health information allows for improved communications, coordination, and efficiencies across care settings. HIT supports patient-centered care and health equity by ensuring that the right health information is available to health systems, providers, and patients at the right time and place.

To give a few examples, HIT helps:

- Providers securely gather, store, and share patients' clinical data so the care team can work together to provide care;
- Providers track and report on quality measures, which support efforts to hold the health care system accountable for delivering high-quality care;
- CCOs, health insurance companies, and providers analyze data to identify health disparities in patients to target further care; and
- Patients view their health information to better understand their care and ensure their information was captured accurately.

What is HIT?

HIT is technology that stores, retrieves, shares, or uses health information, such as diagnoses, medications, allergies, records of doctors' visits, hospital admissions, lab results, and more.

Health care providers, health plans, CCOs, health systems, hospitals, clinics, and other organizations use HIT to manage their businesses and take care of patients.

Patients, families, and caregivers use HIT to access the patient's health information, communicate with providers, and manage health conditions.

Two forms of HIT foundational to all other HIT efforts include the electronic health record (EHR) and health information exchange (HIE). People receive higher quality of coordinated care when their providers have access to their health information at the point of care. This promotes safer and better-informed clinical decisions, especially when it is easily accessible within the provider's workflow.

EHR

Allows providers to electronically collect, store, and use clinical information. This includes collecting other data, such as screenings, assessments, and demographic information.

Helps providers participate in information-sharing and care coordination, contribute clinical data for quality reporting and population health efforts, and engage in value-based payment arrangements.

Supports sharing information with patients, their families, and their caregivers.

HIE

Allows electronic health information sharing in real-time across providers with differing disciplines and organizational affiliation. There are different types of HIE tools and networks, and many have the capability to interface with an EHR to allow a seamless exchange of information.

Improves coordinated care through sharing clinical data in real-time.

Supports referrals, notifications about critical health events, and access to prescription or other important clinical patient information

Oregon providers, hospitals, health systems, CCOs, health insurance companies, community-based organizations, and other users connect to a variety of additional HIT tools and networks such as community information exchange (CIE), population health and analytic tools, and patient apps. Each organization, provider type, and patient choose the tools that work best for them and their community.

The 2022 HIT Data Report to the Health Information Technology Oversight Council outlines the landscape of HIT in Oregon, focusing primarily on EHR adoption and HIE access. Oregon has high rates of EHR adoption when compared to other states. However, when we compare EHR adoption rates of physical, behavioral, and oral health providers, a clear digital

divide remains. Overall, HIE in Oregon has increased significantly, with major gains in hospital event notifications through the EDIE/Collective Platform and nationwide query-based networks such as Carequality. Hospitals and health systems have the highest adoption rates, and physical health providers' rates have also increased. Behavioral and oral health providers are participating, but at lower rates. Federal financial incentives have contributed largely to the adoption and spread of HIT for hospitals and physical health providers. Although health care and government have made substantial investments in HIT, gaps remain. Some examples include:

- Electronic health information may be inaccessible to patients who read languages other than English or lack Broadband or smartphones
- Lack of trauma-informed person-centered data collection, analysis, reporting, and sharing (for example, patients often have to share their story repeatedly to different providers due to gaps in information sharing)
- Concerns over privacy and security protections create barriers in sharing health information
- Disparities in federal financial incentives led to a digital divide with certain provider types, especially behavioral health
- Lack of financial resources for providers to adopt or use HIT, or to connect to HIE networks to access additional information outside the provider's EHR
- Limited availability of an EHR that is designed to meet the needs of the provider type
- Limited clinic staff capacity and HIT expertise

HIT and CCOs

The core of Oregon's health system transformation efforts, the CCO coordinated care model, relies on HIT to succeed. CCOs are in a unique position to not only utilize HIT tools within their organization to assist with caring for Medicaid members, but also to support physical, oral, and behavioral health providers in their adoption and use of HIT. In addition, investing in the community's health by sponsoring, incentivizing, and helping patients, providers, and community-based organizations with adoption of HIT tools contribute to the overall well-being of Medicaid members.

Changes in this December 2022 release

- New exclusions to HRS HIT spending, based on CCO contractual requirements, have been added (page 5).
- Changes have been made to the HRS HIT spending examples (pages 5-6), including minor updates to hospital event notification and population health and analytics tools, and removal of the provider network example due to inconsistency and lack of coherent alignment with HRS.

HRS criteria for HIT

HRS are defined as services intended to improve care delivery and overall member and community health and well-being. For spending to be considered HRS, it must meet requirements for either 1) activities that improve health care quality in line with 45 CFR 158.150 or 2) be related to HIT and meaningful use requirements to improve health care quality. The HIT focus is further described in 45 CFR 158.150 as activities that enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of HIT in line with 45 CFR 158.151. As noted in 45 CFR 158.151, this includes one or more of the following:

1. Making incentive payments for health care providers for the adoption of certified electronic health record technologies (CEHRT) and their meaningful use, as long as the payments are not included in reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of CEHRT by health care providers;
3. Providing technical assistance to support adoption and meaningful use of CEHRT;

4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of:
    a. Costs related to maintaining accreditation by nationally recognized accrediting organizations (for example, the National Committee for Quality Assurance or Utilization Review Accreditation Commission);
    b. Costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, Consumer Assessment of Healthcare Providers and Systems surveys or chart review of Healthcare Effectiveness Data and Information Set measures); and
    c. Costs for public reporting mandated or encouraged by law;
5. Tracking whether specific medical interventions or a bundle of related services leads to better patient outcomes;
6. Advancing the ability of members, providers, issuers, or other systems to communicate patient-centered health information rapidly, accurately, and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care;
7. Reformatting, transmitting, or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or
8. Provision of EHRs, patient portals, and tools to facilitate patient self-management.

In Oregon, there are many opportunities for HRS spending on HIT to improve overall member and community health and well-being. This can look different for each CCO. Supporting the adoption, implementation, and use of HIT tools helps eliminate health inequities and supports improved integration and coordination of care for all members. The following HIT tools may be aligned with HRS criteria for HIT spending:

- EHRs: support physical, behavioral, and oral health providers with their adoption and use, including technical assistance and incentives
- CIE: sponsoring CIE in the community, including CCO adoption and support physical, behavioral, and oral health providers with their adoption and use; incentives and technical assistance for social services and community-based organizations to eliminate barriers, adopt, and use
- HIE: CCO utilization; support physical, behavioral, and oral health providers' connection or onboarding with a community based HIE, including technical assistance and incentives
- Hospital event notifications: support physical, behavioral, and oral health providers' access to a hospital event notification tool
- Population health and analytic tools
- Patient access to health information: improvements to patient portals, including multiple language options; support members' use of smart phones for access to health information through apps
- Interoperability of HIT tools

Some HIT expenses are considered administrative, and may not meet the criteria for HRS. The following types of HIT spending are excluded from HRS by federal regulation (45 CFR 158.150 (c)):

- Spending to support "fraud prevention activities";
- Spending to support standard or electronic facsimile (e.g., faxing or efax);
- Spending "paid for with grant money or other funding separate from premium revenue"; and,
- Spending for, "Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act"

Additionally, CCO contractual requirements for HIT, which can change year to year, are excluded from HRS. The following are examples of required, HIT efforts that are excluded from HRS:

- Funding CCO access to a web-based information exchange that provides real-time hospital event and utilization data. See examples table below for using HRS to provide access to non-CCO entities.
- Funding for activities that support developing and implementing the CCO contractually required provider directory.
- Funding for activities to support requirements under the CMS Interoperability and Patient Access Final Rule and OAR 410-141-3591. Federal rules are accessible on OHA's Office of Health Information Technology webpage.
- Funding for required CCO activities and administrative functions that support provision of covered services, including covered services that address CCO member health-related social needs.

Examples of HIT services and supports that qualify as HRS

The table below briefly summarizes examples of accepted CCO HRS as well as potential HIT services that could qualify as HRS. The number of examples will be expanded over time to improve peer-to-peer CCO sharing.

Note that all HIT spending is, by definition, community benefit initiative HRS because it is focused on improving population health and health care quality and is not limited to OHP members. However, for tracking purposes, CCOs report HRS HIT spending separately from HRS CBI spending.

HIT Initiative	Qualifies as HRS?
HIT: Electronic Health Records (EHR)	
Funding for local public health to purchase and implement a new EHR that allows for better communication with members and significantly increases reporting capabilities to address member gaps in care and track quality outcomes.	**Yes**
Purchase and implementation of a community based EHR to improve member care by compiling all current and historical health records, including pharmacy, imaging, procedures, and hospitalization. The EHR will better address gaps in care and support coordination.	**Yes**
HIT: Health Information Exchange (HIE)	
Funding the onboarding of provider organizations to a community-based HIE.	**Yes**
HIT: Community Information Exchange (CIE)	
Purchase and implement a CIE, including vendor fees and non-CCO or non-clinic staffing, to support a robust CIE accessible by health care providers, social service providers, and community-based organizations. The CIE enables resource-matching with referrals, tracks data and outcomes for community members' health-related social needs, and supports close-looped referrals between health care providers, community-based organizations, and other social service providers.	**Yes**
HIT: Hospital Event Notifications	
Funding access for organizations beyond the CCO, such as primary care clinics and other care providers, to a web-based information exchange that provides real-time hospital event and utilization data. The HIT tool supports effective health information sharing and care coordination for members accessing the emergency department or inpatient hospital settings. In addition, users can push care plan information and recommendations into the systems for other users to view.	**Yes**

HIT: Interoperability	
Through a third-part app, providing members a Patient Access API (Application Program Interface) to access their claims, encounter, and clinical information.	**No:** This is a CCO contractual requirement and excluded from HRS
HIT: Population Health and Analytics Tools	
Purchase and implementation of tools that combine data from the EHR and payer claims. The combined data provides an aggregated view of members' overall health and contributing factors, gap lists, risk scores, and tracks quality outcomes. Information is accessed by members of the care coordination team and can be made available to other treating care providers.	**Yes**
Data cleaning and workflow development to support a population health platform that uses EHR and claims data. The platform, in line with best practices, leverages population-health data to better identify and address member gaps in care and track quality outcomes.	**Yes**
HIT: Telehealth	
Equipment and supplies for **members** to better connect with health information through apps for improved health and to facilitate self-management.	**Yes**
Equipment and supplies **for providers or clinics** to provide telehealth care coordination and treatment for at risk behavioral health clients.	**No:** Clinic-based telehealth equipment does not meet HIT criteria for HRS.

Resources

1. OHA's Office of HIT resources, including Oregon's Strategic Plan for HIT and HIE, educational materials, and reports: https://www.oregon.gov/oha/HPA/OHIT/Pages/Resources.aspx
2. OHA's 2019 HIT Report to Oregon's HIT Oversight Council: https://www.oregon.gov/oha/HPA/OHIT/Documents/2019HITReport_HIEOverview_TwoWorlds_Combined.pdf
3. The Oregon Health Leadership Council's HIT Commons is a shared public/private governance model designed to accelerate and advance Health Information Technology adoption and use across the state: https://orhealthleadershipcouncil.org/hit-commons/
4. OHA's HRS webpage: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx
5. OHA's SHARE webpage: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx
6. OHA's ILOS webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/ILOS.aspx
7. OHA's 1115 Medicaid waiver webpage: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx
8. OAR 410-141-3500: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265499
9. OAR 410-141-3845: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265554
10. 45 CFR 158.150: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-158/subpart-A/section-158.150
11. 45 CFR 158.151: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-158/subpart-A/section-158.151

Contact

For comments and questions, please email the OHA HRS team at health.relatedservices@oha.oregon.gov.

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