Policy Level

PL-DE Health Information Technology

Agency Recommendation Summary Text

The Health Care Authority (HCA) requests an increase of $22,881,000 ($2,708,000 GF-State) in the 2018 Supplemental to improve health outcomes and reduce health expenditures for the highest risk, most complex, and costliest Medicaid clients by expanding the utility and volume of data within a secure, centralized Clinical Data Repository (CDR) service.

Fiscal Summary

Operating Expenditures	FY 2018	FY 2019	FY 2020	FY 2021
Fund 001-1 GF-State	$96,000	$2,612,000	$1,766,000	$1,477,000
Fund 001-C GF-Medicaid	$408,000	$19,765,000	$10,333,000	$7,732,000
Total Cost	$504,000	$22,377,000	$12,099,000	$9,209,000
Staffing	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
FTEs				
Revenue	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Fund 001-C GF-Medicaid	$408,000	$19,765,000	$10,333,000	$7,732,000
Total Revenue	$408,000	$19,765,000	$10,333,000	$7,732,000
Object of Expenditure	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
Obj. E – Goods & Services	$480,000	$22,353,000	$12,075,000	$9,185,000
Obj. G – Travel	$24,000	$24,000	$24,000	$24,000

Package Description

Background

Previous state and federal investments in Washington have enabled providers with certified electronic health record (EHR) systems to share clinical data over the statewide Health Information Exchange (HIE). Starting in 2017, health care organizations with certified EHR systems that contract with Medicaid managed care organizations (MCO) are now required to upload clinical care summaries to a centralized CDR managed and hosted by the state's HIE partner, OneHealthPort (OHP). This contractual requirement will result in near real-time care summary reporting for approximately 1.4 million of the 1.8 million active Medicaid clients.

HCA manages the state's HIE and CDR service in partnership with OHP and in compliance with national standards in order to increase interoperability between systems, and safeguard security and confidentiality of information.

Problem to Be Solved

Previous federal funding limitations meant only about 300 provider organizations have access to incentive payments to off-set investments in certified EHR and HIE technology. Many Medicaid provider types who are not eligible for EHR incentives, such as first responders, long-term care, mental health, substance abuse treatment, correctional health, and public health providers are the groups most likely to be involved with the most complex and high risk clients. Further, many of these provider may not use certified EHR technology or other health IT. In addition, previous allocations limit data reported in the CDR to managed care clients only.

In February 2016, the Office of the National Coordinator loosened the constraints on receiving enhanced federal funding participation (FFP) at the 90 percent match rate for certain EHR and HIE related activities. The Agency requests authorization to claim those, along with Medicaid Management Information System (MMIS) operational FFP at the 75 percent match rate, to fill significant and critical gaps in the HIE and CDR service. The Agency proposes investments in several categories to expand pathways for all providers to access clinical data for all Medicaid clients to improve outcomes, coordination of care, and reduce costs. The proposed investments will support service delivery transformation in the state by:

1) **Expanding data to include all Medicaid clients:** Enabling all Medicaid clients, not only those in a MCO, to have their clinical information in a centralized data repository. Supporting information exchange on behalf of these individuals is critically important as they are among the most vulnerable, clinically complex, and costly populations. This provides continuity of care and coordinated care planning as clients move in and out of different settings with changing Medicaid eligibility (e.g., correctional facilities, involuntary commitment);
2) **Expanding access to all Medicaid providers:** Enabling all Medicaid providers to participate in the secure sharing and use of integrated health information in a universally accessible record regardless of availability of certified EHR system. This supports coordination of care for the most complex, high risk and costliest clients across multiple provider groups and care settings, particularly the small percentage of Medicaid clients who account for a disproportionate share of services due to medical, mental health, and substance abuse treatment needs;
3) **Improving outcomes and reduce administrative burden:** Improving access to clinical information at the point of care, notifying individuals and organizations responsible for improving health outcomes when their patient is in crisis, and significantly reducing the administrative burden for manually reviewing patient records for quality reporting. This controls costs by reducing duplicative services and diagnostic tests across multiple care settings;
4) **Leveraging enhanced FFP:** Guidance from the federal Centers for Medicare and Medicaid Services on HIE funding released in February 2016 expands the scope of HIE investments that are eligible for 90 percent FFP. This request takes advantage of this unique, time-limited opportunity to further the sharing of electronic clinical records by investing in services and tools that were not previously eligible for enhanced federal funding;
5) **Investing in scalable and re-usable solutions:** Although the purchased service and tools are intended for Medicaid, several are expandable and reusable for other payers and providers in Washington with similar needs, including providers who serve clients in correctional settings;

6) **Supporting real-time performance monitoring:** Enabling real time performance monitoring of individual patient health and dashboard reports reflecting patient care and services delivered across multiple care settings.

Detail for Proposed Investments

Specific investments to create a comprehensive view of clinical data in the CDR for all Medicaid clients and all provider types include the investments described below:

1) **Build reusable interfaces:** Support clinical data sharing and break down cost barriers from EHR vendors.
   a. Develop interfaces for ambulatory practices' EHR systems to the statewide HIE and CDR.
   b. Advances integration of behavioral health by reducing costs for submitting mental health and substance use disorder (SUD) data to the CDR through the HIE.
   c. Develop interface for DSHS instance of Cerner EHR for state hospitals.
   d. Develop interface to HIE for Local Health Jurisdictions (LHJ) for use of CDR.
2) **Offer onboarding incentive bundle and technical assistance:** Offset some of the one-time costs for Medicaid ambulatory providers that join the HIE to contribute, access and use care summaries.
   a. Provide funding for consultation, readiness, and training support for mental health and SUD providers without EHR systems to access and use integrated clinical health information in the CDR via a portal. Assistance may be delivered via regional practice transformation hubs.
   b. Set triggers in EHR systems to automatically contribute care summaries after each Medicaid patient visit.
   c. Invest in a solution to enable behavioral health integration by enhancing privacy classification capabilities for BH/SUD information.
   d. Submit provider directory data elements to the statewide HIE vendor, OHP, for CDR dashboard reporting.
3) **Acquire extraction and record locator tools:** Develop tools that locate and move data from one source to another.
   a. Invest in data extraction and transformation tools to enable BH, SUD, and other providers to contribute information from their non-certified EHR system to the integrated health record.
   b. Extract large data sets from the CDR for sharing with HCA and authorized organizations for advanced analysis of health outcomes and performance measures using clinical data sets.
   c. Acquire record locator service to access diagnostic imaging reports and images from CDR.
4) **Expand CDR clients and data:** Increase Medicaid client records and data elements stored in the CDR.
   a. Add Fee for Service clients.
   b. Develop integration for Health Homes and Health Action Plan data for care givers to complete health assessments and transmit to the CDR for coordination.
   c. Make information from Department of Health's (DOH) Prescription Drug Monitoring (PDM) program and Immunization registry available to Medicaid providers via the CDR.
   d. Implement solution for consent management that allows for sharing of SUD information as part of the integrated health record.
5) **Expand Alerts**: Expand the ability to inform providers of critical events.
   a. Make alerts to providers and care coordinators available to share information at times of transition (e.g., when Medicaid covered individuals enter correctional settings to support continuity of mental health and substance abuse treatment) and support the inclusion of care coordinators in the overall treatment planning as needed.

6) **Integration with larger statewide efforts**: Ensure that HIT/HIE efforts coordinate with State and Federal projects.
   a. Examine ACH projects, evaluate HIT/HIE gaps, and develop solutions to address gaps and support the acquisition and use of needed HIT/HIE solutions
   b. Increase travel funds to provide more direct support and interaction with providers within the state, and increase state presence at federal HIT/HIE convenings

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Decision Package Justification and Impacts

Performance Measure Detail:

Activity Inventory
H003 HCA Information Technology

What specific performance outcomes does the agency expect?

HCA expects the proposed investments to achieve the following outcomes by the end of the 2017-2019 Biennium:

- **Expand Client Records**: Add 400,000 Medicaid fee for service clients to the CDR (clinical information for 1.4 million Medicaid clients served by health care organizations is currently funded to be in the CDR).
- **Expand Data Elements**: Build out the clinical record in the CDR to include additional data elements specific to behavioral health (mental health and substance use disorder), and care planning. Assumes 200 behavioral health and long term care organizations will contribute additional data.
- **Reduce Costs for Duplicative Services and Diagnostics**: Minimize the number of repeated services and diagnostics when a client moves to a different managed care organization or health care setting. HCA expects this will reduce un-necessary duplicative services and diagnostics by 10 percent.
- **Support Patient Directed Information Exchange.** Enable patient directed consent management for the exchange of substance use information.
- **Support Health Information Exchange.** Support electronic health information exchange across the care continuum, including by providers who are not eligible for the Medicaid EHR Incentive Program.
- **Promote Coordinated Care Planning for Highest Risk Clients**: Expand access to integrated clinical information to support coordinated care planning for the highest risk, most costly clients resulting in 6,000 cases coordinated electronically across providers.
- **Expand Outcome Monitoring**: Add dashboard reporting to the CDR for health care organizations, authorized providers, and health plans to monitor quality and performance and specific health outcomes for patient populations by diagnosis, location, etc. Assumes 300 organizations with a certified EHR access dashboard reporting.
- Advanced Analytics Reporting: Establish critical mass of aggregated, de-identified clinical information for population health management, clinical program review and advanced data analytics and research. Assumes clinical information for 1.8 million Medicaid clients will be available for advanced analytics on

health outcomes for value based purchasing.

What alternatives were explored by the agency and why was this option chosen?

HCA considered a number of alternatives to meet the business needs of sharing integrated clinical data for all Medicaid clients across all provider types. HCA evaluated the various alternatives and chose to leverage previous investments in the HIE, EHR and CDR infrastructure that is sustainable and scalable as it maximizes enhanced federal match at 90 and 75 percent FFP, reduces risks by leveraging technical expertise found in existing relationships with multiple external vendors, and brings the solution to the health marketplace as quickly as possible so the benefits and expected outcomes are immediately available.

Other alternatives that were considered included:

1. Develop "point to point" connections between providers rather than leverage the existing HIE and CDR centralized infrastructure;
2. Develop technical solutions in house rather than leverage existing vendor contracts;
3. Limit collection and sharing of data to those medical providers with certified EHR systems only rather than expand to allow data from behavioral health provider groups; and
4. Require providers to develop and pay for isolated solutions, rather than centralized solutions funded by newly expanded availability at 90 percent FFP.

None of the alternatives above meet the business needs of the healthcare community, Washington residents, or HCA. These alternatives are higher risk, more burdensome, costlier, and do not meet the need of a comprehensive, centralized CDR for all Medicaid clients and provider types.

The preferred alternative also meets the goals of the Governor's effort under Healthier Washington to integrate care delivery for physical and behavioral health using integrated health information, person centered care delivery, and better care outcomes at a lower cost.

What are the consequences of not funding this request?

This is a time-limited funding opportunity with the Federal Government at a highly beneficial matching rate. This opportunity enables a big leap forward for integrating physical, behavioral, and public health in way that benefits community partners and providers who have not been eligible for these opportunities before.

Without this funding request, clinical data sharing will be limited to those providers with certified EHR systems only. The clinical record will be incomplete only reflecting care from traditional large clinics and hospitals and will not reflect behavioral health (substance abuse treatment and mental health services) and other community based services from providers without certified EHR systems. A limited number of providers will have access to a limited data set. Care planning and coordination across provider types and care setting will not be possible. Services and/or diagnostics will be duplicated and/or preventative services such routine health screenings will be missed causing increased health costs. Additionally, advanced analytics of health outcomes and value based purchasing will not be possible without a complete clinical record for all Medicaid clients.

How has or can the agency address the issue or need in its current appropriation level?

Within its current appropriation level, HCA has made significant foundational investments in sharing health information electronically across eligible Medicaid providers throughout the state. The current request leverages

these investments to realize the objectives and outcomes of a healthier population in Washington State. Critical activities funded through the current appropriation level include:

- HCA is contributing to the operational cost of a centralized CDR service that is a component of the Medicaid Management Information System. As a service provided by the statewide HIE vendor, it can be used as a community asset to collect, share and use integrated health information currently housed in disparate systems that don't communicate with each other.
- HCA has established a method for authorized providers to view health information within the CDR using their own electronic health record system as well as a web-based option if they don't have an electronic health record system.
- HCA has provided leadership on privacy and security policies, practices and implementation including leading an Interagency Privacy Workgroup providing guidance to the healthcare community on safeguarding personal health information, and performing on-going evaluation of HIE and CDR solutions in collaboration with OHP to ensure these investments meet all federal and state regulations for security and privacy.
- HCA has leveraged existing contract authority to require health care organizations contracted with MCOs with certified electronic health record systems to upload care summaries to the CDR each time they see a Medicaid patient beginning in 2017. HCA will seek to identify and implement additional opportunities to support and advance health information exchange via our contract authority.
- HCA has the ability within current funding levels to provide for professional services or staff to develop educational materials to promote a shared understanding of what is allowable under state and federal law and how to apply the technical and data safeguards when sharing information to and from the CDR. Educational materials will be made available to provider organizations to inform and guide them regarding the exchange of information via the CDR.
- HCA has the ability within current funding levels to develop a core set of Consolidated Health Dashboard Reports using clinical, claim, and encounter data within the CDR. Dashboards will be made available on demand to provider organizations and those accountable for health outcomes and performance measuring.
- HCA has the ability within current funding and staffing levels to conduct a gap analysis to identify the data elements needed by behavioral health providers, health homes and other care coordinators that are not currently present in the CDR. HCA can identify options for modifying the CDR to include additional data elements (such as assessment scores and care plan activities) through an upload process or direct data entry.
- HCA has within current funding levels staff and IT vendor services for the administration of the EHR incentive payment program; including funding for the incentive payments that qualify for 100 percent FFP.
- HCA has within current funding levels staff and consulting project management services for the implementation of HIE initiatives.
- HCA has within current funding levels on-going management fees for the CDR.

Provide references to any supporting literature or materials:

Summary of CDR Service

Summary findings of environmental scan

Washington State Health Care Authority

Summary of investment weighting

Base Budget

If the proposal is an expansion or alteration of a current program or service, provide information on the resources now devoted to the program or service.

Based on carry forward level, HCA annual budget currently contains $81,671,000 ($436,000 GF-State) to issue federally funded incentive payments, manage the provider incentive program and to plan and launch other initiatives related to the State Medicaid Health IT Plan (SMHP).

Expenditure, FTE and Revenue Assumptions, Calculations and Details:

Expenditure		FY 2018	FY 2019	FY 2020	FY 2021
1) Build re-usable interfaces to support clinical data sharing and break down cost barriers from EHR vendors.	Implementation	$0	$2,587,000	$1,332,000	$951, 000
	Maintenance	$0	$0	$0	$0
2) Offer onboarding incentive bundle and technical assistance: Offset the costs for ambulatory providers to join the HIE, contribute, access and use care summaries.	Implementation	$0	$10,035, 000	$8,781, 000	$6,272, 000
	Maintenance	$0	$0	$421, 000	$421, 000
3) Acquire extraction and record locator tools: Develop tools that locate and move data from one source to another.	Implementation	$0	$5,815,000	$0	$0
	Maintenance	$96,000	$667,000	$667,000	$667,000
4) Expand CDR patients and data: Increase patient records and data elements stored in the CDR	Implementation	$100,000	$1,350,000	$0	$0
	Maintenance	$179,000	$679, 000	$679,000	$679, 000
5) Expand Alerts: Expand the ability to inform providers of critical events	Implementation	$0	$780,000	$0	$0
	Maintenance	$0	$195,000	$195,000	$195,000
6) HIT/HIE Integration with larger statewide efforts	Implementation	$129,000	$269,000	$24,000	$24,000
	Maintenance	$0	$0	$0	$0
	Total	**$504,000**	**$22,377,000**	**$12,099,000**	**$9,209,000**
	GF-State	$96,000	$2,612,000	$1,766,000	$1,477, 000
	GF-Medicaid	$408,000	$19,765,000	$10,333,000	$7,732, 000

Washington State Health Care Authority

Impacts to Communities and Other Agencies

Fully describe and quantify expected impacts on state residents and specific populations served.

The funding requested in the proposal shall allow HCA to improve data flow resulting in better informed decisions at the point of care, reducing risks to 1.8 million Medicaid clients and the potential to avoid duplicative services and diagnostic testing. The funding request also allows other social and health service organizations access to new clinical data sets for case management, care coordination, population management and to guide decisions on state service delivery.

What are other important connections or impacts related to this proposal?

Does this request have:

Regional/county impacts?	Yes ☒ No ☐
Other local government impacts?	Yes ☒ No ☐
Tribal government impacts?	Yes ☒ No ☐
Other state agency impacts?	Yes ☒ No ☐

Does this request:

Have any connection to Puget Sound recovery?	Yes ☐ No ☒
Respond to specific task force, report, mandate or executive order?	Yes ☐ No ☒
Contain a compensation change?	Yes ☐ No ☒
Require a change to a collective bargaining agreement?	Yes ☐ No ☒
Create facility/workplace needs or impacts?	Yes ☐ No ☒
Contain capital budget impacts?	Yes ☐ No ☒
Require changes to existing statutes, rules or contracts?	Yes ☒ No ☐
Have any relationship to or result from litigation?	Yes ☐ No ☒

If "Yes" to any of the above, please provide a detailed discussion of connections/impacts.

Community and Tribal Impacts:

The proposal enables communities to connect and share information among health care organizations, city and county jails, local health jurisdictions, and tribal health clinics; and collect critical information for population health management and state program and purchasing decisions.

Those accountable for the quality of care and health outcomes for Medicaid patients are seeking solutions for connecting providers within their regions and networks delivering care and services to Medicaid consumers. A

Washington State Health Care Authority

single platform for this communication and the ability for all types of providers to participate is a foundational element to delivering integrated care.

Medical professionals serving individuals in county and city jails currently have no health information available to them during intake which is critical in the first 24 to 72 hours. The risk to the counties is high when they aren't aware if someone has a communicable disease, is receiving or in need of mental health services, has a set of complex health conditions or on medications critical to the individuals' health.

Hospitals do not have access to primary care records or health services delivered in tribal clinics which results in duplicative diagnostic testing and increased costs.

Other Agency Impacts:

Information held within the DOH in immunization registries and prescription drug monitoring program is of high value to primary care providers and settings where patients present themselves in a crisis mode (hospitals, jails, first responders).

Department of Social and Health Services (DSHS) contracts with a broad set of Medicaid providers to deliver long-term care and support services in a variety of facilities and in home settings as well as behavioral health services through Behavioral Health Organizations (BHO). They are key partners in caring for and coordinating services for some of the most vulnerable citizens and those with very complex health care needs.

Contractual Impacts:

HCA intends to leverage existing vendor contracts to the extent possible to provide the technical and consulting services identified above. To accommodate potential expanded scope, contract amendments will be required.

Information Technology (IT)

Does this request include funding for any IT-related costs, including hardware, software, services (including cloud-based services), contracts or IT staff?

☐ No

☒ Yes Continue to IT Addendum below and follow the directions on the bottom of the addendum to meet requirements for OCIO review.)

Washington State Health Care Authority

2018 Supplemental Information Technology Addendum

Part 1: Itemized IT Costs

Please itemize any IT-related costs, including hardware, software, services (including cloud-based services), contracts (including professional services, quality assurance, and independent verification and validation), or IT staff. Be as specific as you can (See chapter 12.1 of the operating budget instructions for guidance on what counts as "IT-related costs").

Expenditure	FY 2018	FY 2019	FY 2020	FY 2021
1) Build re-usable interfaces to support clinical data sharing and break down cost barriers from EHR vendors.	$0	$2,587,000	$1,332,000	$951, 000
2) Offer onboarding incentive bundle and technical assistance: Offset the costs for ambulatory providers to join the HIE, contribute, access and use care summaries.	$0	$10,035, 000	$9,202, 000	$6,693, 000
3) Acquire extraction and record locator tools: Develop tools that locate and move data from one source to another.	$96,000	$6,482,000	$667, 000	$667, 000
4) Expand CDR patients and data: Increase patient records and data elements stored in the CDR	$279,000	$2,029,000	$679,000	$679, 000
5) Expand Alerts: Expand the ability to inform providers of critical events	$0	$975,000	$195,000	$195,000
6) HIT/HIE Integration with larger statewide efforts	$129,000	$269,000	$24,000	$24,000
	$504,000	**$22,377,000**	**$12,099,000**	**$9,209,000**
GF-State	$96,000	$2,612,000	$1,766,000	$1,477, 000
GF-Medicaid	$408,000	$19,765,000	$10,333,000	$7,732, 000

Part 2: Identifying IT Projects

If the investment proposed in the decision package is the development or acquisition of an IT project/system, or is an enhancement to or modification of an existing IT project/system, it will also be reviewed and ranked by the OCIO as required by RCW 43.88.092. The answers to the three questions below will help OFM and the OCIO determine whether this decision package is, or enhances/modifies, an IT project:

Question	Answer
Does this decision package fund the development or acquisition of a new or enhanced software or hardware system or service?	Yes ☒ No ☐
Does this decision package fund the acquisition or enhancements of any agency data centers? (See OCIO Policy 184 for definition.)	Yes ☐ No ☒
Does this decision package fund the continuation of a project that is, or will be, under OCIO oversight? (See OCIO Policy 121.)	Yes ☐ No ☒

If “Yes” to any of these questions, complete a concept review with the OCIO before submitting this budget request. Refer to chapter 12.2 of the operating budget instructions for more information.