Agenda

• Mental Health IMD Waiver Application
• 42 CFR Part 2 Guidance
• Data Governance Update
• Data Sovereignty
• ONC and CMS Proposed Rules
• Glossary of Key HIT terms
• Gravity Project
1115 MH IMD Waiver Application
1115 MH IMD Waiver Background

- Federal rules prohibit the use of Medicaid funds for services to individuals who reside in an Institution for Mental Disease (IMD) for more than 15 days during a calendar month.
- In 2016 CMS offered states the opportunity to apply for an 1115 demonstration waiver allowing Medicaid-funded treatment in SUD IMDs.
- In 2017 Washington State was granted an 1115 waiver amendment for SUD IMD facilities. The amendment application required the state to make changes to its SUD treatment system.
- A 2018 executive order allows 1115 waivers for MH IMD facilities.
1115 MH IMD Waiver Background

- Requirements **similar** to those under the SUD IMD 1115 Waiver:
  - States must meet milestones within two years.
  - Requires an average 30 day stay during the demonstration.
  - States will report quarterly on a common set of metrics.
  - Requires an approved implementation plan and updated HIT plan before state begins using Medicaid for MH IMDs.

- Requirements **different** than those under the SUD IMD Waiver:
  - Does not apply to individuals under age 21 unless they reside in certain IMD facilities (e.g. PRTF).
  - Maintenance of financial effort will be **considered** when reviewing applications, in order to ensure states continue to fund outpatient services.
  - Requires accredited facilities.

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1115 MH IMD Waiver Timeline

- The target date for approval and implementation is July 1, 2020.
- The state is seeking technical assistance and further guidance from CMS regarding application requirements.
MH IMD Waiver HIT Plan Tasks

• Required assurances:
  1. Sufficient HIT infrastructure/ecosystem to achieve the goals of the demonstration, and if not how that will be achieved and over what time period.
  2. SUD HIT Plan is aligned with the state’s broader State Medicaid Health IT Plan (SMHP)
  3. On intent to include emerging national HIT standards in Medicaid Managed Care contracts (e.g., referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management)
MH IMD Waiver HIT Plan Tasks

• HIT tasks related to:
  o Closed Loop Referrals and e-Referrals
  o Create and use Electronic Care Plans
  o Medical Records Transition
  o E-consent
  o Interoperable Intake, Assessment, and Screening tools
MH IMD Waiver HIT Plan Tasks

- HIT tasks related to:
  - Telehealth technologies facilitates broader access to integrated MH care and primary care
  - Identify patients at risk for discontinuing/stopping treatment and notifying care teams
  - Care coordination workflow for patients experiencing first episode of psychosis
MH IMD Waiver HIT Plan Tasks

• HIT tasks related to:
  o Tagging/linking child and parents EHRs (for care coordination)
  
  o EHRs capture all episodes of care and linked to the correct patient
42 CFR Part 2 Guidance
Welcome

“It is more important than ever for health care providers to think about and address ‘whole person’ health.”

- DR. CHARISSA FOTINOS
The need for consent care coordination

<table>
<thead>
<tr>
<th>Type of provider</th>
<th>Applicable law*</th>
<th>Authorization requirements for release of records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health provider</td>
<td>HIPAA</td>
<td>Consent not required for TPO**</td>
</tr>
<tr>
<td>SUD providers</td>
<td>42 CFR Part 2</td>
<td>Consent required</td>
</tr>
</tbody>
</table>

* HIPAA: Health Insurance Portability and Accountability Act
** TPO: Treatment, Payment, and Health Care Operations

42 CFR Part 2 (also known as Confidentiality of Alcohol and Drug Abuse Patient Records) – A federal statute that governs confidentiality for people seeking treatment for substance use disorders from federally assisted programs. This law generally requires a federally assisted substance use program to have a patient’s consent before releasing information to others. It encourages people to seek treatment and reassures patient privacy. Additional information found here: https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines

* RCW 70.02 – Medical Records – Health Information Access and Disclosure is presumed to still apply. RCW 70.02

**Treatment, Payment, and Health Care Operations
Recent history

1970 PRESENT

1972
Underlying legislation passed

1975
Part 2 finalized

1987
Part 2 updated

2017
Part 2 updated

2018
Part 2 updated

2019
Notice of proposed rulemaking expected march 2019

Washington State Health Care Authority
Issues with implementing 42 CFR Part 2

**Current Situation:**
- 42 CFR Part 2 confusing to providers
- Over exclusion of SUD information by providers
- No consistent mechanism for sharing
- Burdensome requirements dissuading providers from asking for consent

**Gaps**

**People:**
- Inconsistent understanding of 42 CFR Part 2
- Adverse outcomes due to lack of sharing information for patient care (lack of full integration)

**Policy & Process:**
- Lack of statewide guidance regarding 42 CFR Part 2
- Need for a consent form allowing for HIE designation

**Technology:**
- Need for HIE to leverage recent SAMSHA updates
- Partner agencies/providers utilize numerous systems
How the toolkit fills in the gaps

**People:**
- Inconsistent understanding of 42 CFR Part 2
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**Policy & Process:**
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**Resources in the guidance document**
- Legal guidance
- Real world scenarios
- Provider consent script
- Patient informational brochure
- Part 2 compliant consent form that accommodates HIE
- Overview videos offering introduction to Guidance document
Here is an example of decision tree in used in the guidance document.
A person receiving substance use disorder treatment may have many people involved in their care. For example, the person may see physical health providers, receive outpatient services from a substance use disorder provider, and receive other community based services. The person benefits when all the people involved in their care can communicate with each other.
Treatment Scenario 3 | Medical Emergency

Key take away: Part 2 information can be shared without consent with emergency personnel when responding to a legitimate emergency.

**Scenario Description:**
- A person who is experiencing a medical emergency arrives at an emergency facility. The treating provider is aware that the person has previously been treated for SUD by a Part 2 provider, but it is not possible to obtain consent to receive SUD information.
- A Part 2 program may be located within a facility that has other functions that are not considered part of the Part 2 program.
- Sharing the same physical location does not mean that all providers are within the Part 2 program.

**42 CFR Part 2 Conditions for Use or Disclosure of SUD Information:**
- Disclosure must be necessary to respond to a legitimate emergency.
- Only applies when informed consent cannot be obtained.
- The Part 2 program provider must document who made the disclosure, why it was made, and when it was made.

**HIPAA and Chapter 70.02 RCW Requirements:**
- Information can be used and disclosed for legitimate treatment purposes without written consent. 42 CFR Part 2 may be more restrictive.

**Suggested things to keep in mind:**

42 CFR Part 2 Requirements
HIPAA & 70.02 requirements
Nine elements of the consent form

1. Name of the patient
2. An explanation of the right to revoke consent
3. When the consent expires
4. The patient’s signature
5. The date the consent is signed
6. Who may make the disclosure
7. Who can receive the information
8. What information may be disclosed
9. Why the information is being disclosed
When introducing patients to the concept of consent management and its purpose, the following three discussion components are recommended:

- Providing a patient consent conference in a non-judgmental environment.
- Setting the clear intention for improved patient care experience.
- Supporting the patient in self-directed decision making around consent and being in control of that decision.
Benefits of the brochure:
Clear language explaining the benefits and describing patient protections
Data Governance Update
Data Governance Update

- Finalizing CDR Data governance charter
- Had a first data governance meeting
- Discussing improving access to data within the CDR
- Discussing expanding data contained in the CDR
Data Sovereignty
Disclaimer

• I am non-Native.
• I am not a data/HIT/HIE expert.
• I happen to sit at the intersection of the Office of Tribal Affairs and Medicaid Transformation.
• My intention with this slide deck is to raise awareness and spur discussion.
Objectives

• Answer the question, “What is data sovereignty?”
• Spur discussion on why this topic comes up for Medicaid Transformation and the work of the Health Care Authority
• Consider next steps
Data Sovereignty, one definition

“Data sovereignty is the concept that information which has been converted and stored in binary digital form is subject to the laws of the country in which it is located.”

- https://whatis.techtarget.com/definition/data-sovereignty
Data Sovereignty, a different definition

“Data sovereignty explains the process by which American Indian tribes regulate all aspects of tribal data, including access, collection, management, analysis and reporting...For too long, tribes have relied on external data sources for tribal decision-making...The necessity to ground data within a tribal sovereignty framework is critical given that the information tribes need to support their own conceptions of development is not being produced by colonial administrative systems. Tribal data are perhaps the most valuable tools of self-determination because they drive tribal nation building by tribes for tribes.”

- Desi Rodriguez-Lonebear
Indigenous Data Sovereignty: Toward an Agenda, 2016
Chapter 14: Building a data revolution in Indian Country
Why data sovereignty?

• Data from whom?
  – Who collects it?
  – How do they collect it?
  – Who do they give the data to?
  – What value are they gaining from collecting the data?

• Data about what and for what?
  – What data are collected?
  – What are the data used for?
  – What analysis do the collectors do?
  – How do the collectors present the data?
Data Sovereignty, Medicaid Transformation and ACHs

- Instances where we (HCA) need to consider data sovereignty
  - Health Information Exchange (HIE)
  - Clinical Data Repository (CDR)
- Instances where you (ACHs) need to consider data sovereignty
  - Pathways Community HUB
  - Data Commons/Exchanges
  - Electronic Health Record acquisition
Where does this leave us?

Is a data solution that does not work for everyone really a solution at all?

vs.

Targeted universalism, where we are all going to the same place, but get there different ways?
ONC and CMS Proposed Rules
ONC and CMS Proposed Rules

• Health IT related rules recently released (officially released on March 4):
  – Comments due June 3

• ONC’s rules on TEFCA:
  – Comments due June 17

• Highly recommend our partners submit comments to CMS and ONC
ONC Proposed Rules
ONC Rule Comments

• HCA supports improving interoperability
• ONC proposed rules should improve provider usage of CEHRT
• General privacy concerns
  – Consider how State agencies and institutions are impacted
  – Create consistency between these requirements and existing law
• Concerns with rapid push to FHIR
  – Lack of mature processes and support for FHIR
  – Impact to existing systems based on other technologies
  – Small and rural provider workflow concerns
• Patient matching: HCA recommends an open, competitive, and transparent forum for patient matching solutions
CMS Proposed Rules
HCA Comments CMS Proposed Rules

• Support: improving data sharing and availability; offer comments on interoperability for CMS/CMMI

• Recommend: adopt the HIT standards for interoperable functional status data elements (DEs) used in LTPAC. Encourage but do not require use of these DEs by physicians and hospitals

• Recommend: Adopt and encourage use of interoperable DEs and exchange standard emerging from the SDOH Gravity Project
HCA Comments CMS Proposed Rules

• Recommend CMS, SAMHSA, and ONC collaborate to:

  – link SAMHSA required TEDS DEs with HIT standards and encourage use

  – identify functional status domains and DEs applicable to persons with BH conditions and IDD, and encourage use

  – set aside of a minimum percentage of SAMHSA Block Grant funds for HIT/HIE investments

  – align 42 CFR Part 2 with HIPAA
Recommend:

• Incentivize adoption and use of interoperable HIT systems / data by BH providers

• Implement competitive grant programs to test interoperable HIE with and by BH providers/others (focusing on adolescents and young adults with SUDs; CAPTA)
Glossary of Key HIT Terms
Glossary of Key HIT Terms

• Developing a glossary to ensure consistent understanding of Health information technology terms

• Examples:
  • *CEHRT-Certified Electronic Health Record Technology*: electronic health record technology that is certified by the Office of the National Coordination for Health Information Technology to meet designated requirements of the Health IT Certification Program (Program). These standards are articulated in various editions (currently edition is the 2015 edition)

  – Please send email to Brad at brad.Finnegan@hca.wa.gov if you have specific HIT terms to be included
Gravity Project
Gravity Project (SDOH)

• The Social Interventions Research and Evaluation Network (SIREN) received funding from RWJF.
• Public collaboration on SDOH domains of: food security, housing stability/quality, and transportation access.
• Steering Committee includes:
  – Federal Government: CMS, ONC, AHRQ, CDC, VA
  – Associations: NCQA, Academy Health, AMA, AHA, NACHC
  – Payers: UnitedHealth Care, Blue Cross/Blue Shield, Kaiser Permanente
Gravity Project (SDOH)

Goals:

• Develop use cases for: screening, diagnosis, treatment/intervention, and planning within EHRs/related systems

• Identify data elements (DEs) and value sets

• Develop consensus-based recommendations on DEs for interoperable exchange and aggregation

• Start development of an HL7® FHIR Implementation Guide
Gravity Project Timeline

SDHCC Roadmap (Phase 1)

Task 1: Collaborative Launch
- Project Charter Development

Task 2: Use Case Development & Functional Requirements
- Use Case Development & Consensus (HL7 Cross-Paradigm Storyboard)

Task 3: Data Set Identification By Domain
- Food Insecurity Data Set Identification
- Housing Instability & Quality Data Set Identification
- Transportation Barriers Data Set Identification

Task 4: Coding Recommendations
- Terminology & Code Harmonization Report Development

Task 5: HL7 FHIR Integration
- HL7 FHIR SDH Implementation Guide Development

Source:
https://drive.google.com/file/d/1QVAp6ETtbwLF0ERocauNDAzojdk5JoOH/view
Gravity Project (SDOH)

• Submitted to Gravity Project:

  – Foundational Community Supports:
    • Fact Sheet
    • Supported Housing Assessments data elements

  – Housing Management Information System:
Gravity Project (SDOH)

- Home page:
  [https://confluence.hl7.org/display/PC/The+Gravity+Project+Home](https://confluence.hl7.org/display/PC/The+Gravity+Project+Home)

- Join:
  [https://confluence.hl7.org/display/PC/Join+the+Gravity+Project](https://confluence.hl7.org/display/PC/Join+the+Gravity+Project)
Monthly HIT Operational Plan Meetings

• 4th Tues. of every month-Next meeting June 25
• Same webinar, phone number, meeting room.  Available at: https://register.gotowebinar.com/register/4052018503263997185
Questions?

More Information:

We anticipate that monthly reports will be posted on HCA Transformation website.


Jennie Harvell,
Health IT Section
jennie.harvell@hca.wa.gov