Connecticut SIM: Health Information Technology

STATE OF CONNECTICUT

HIT work group discussion
Connecticut Valley Hospital
Page Hall, Conf. Room 365,
1000 Silver St, Middletown, CT

May 20, 2013
Objectives for today’s discussion

- Connecticut SIM design aspirations and roadmap
- Care delivery and payment work group considerations
- Key questions and options for designing an HIT infrastructure that supports care delivery and payment innovation
Welcome to the SIM design HIT work group

<table>
<thead>
<tr>
<th>Michael Michaud</th>
<th>Mark Raymond</th>
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<tbody>
<tr>
<td><strong>SIM Associate Project Director</strong></td>
<td><strong>DAS Bureau of Enterprise Technology</strong></td>
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<tr>
<td>Daniel Carmody</td>
<td>Victor Villagra, MD</td>
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<td><strong>CIGNA</strong></td>
<td><em>Ethel Donaghue TRIPP Center (UCHC)</em></td>
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<td>Bernadette Kelleher</td>
<td>James Wadleigh</td>
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<td><strong>Anthem Blue Cross Blue Shield</strong></td>
<td><strong>Access Health CT</strong></td>
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<td>Daniel G. Maloney</td>
<td>Josh Wojcik</td>
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<tr>
<td><strong>Dept. of Public Health (DPH)</strong></td>
<td><strong>Office of the State Comptroller (OSC)</strong></td>
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<td>Dan Olshansky, LICSW</td>
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<td><strong>Dept. of Mental Health &amp; Addiction Services</strong></td>
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<td>Barry Simon</td>
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<td><strong>Gilead Community Services</strong></td>
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<td>Minakshi Tikoo, PhD</td>
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<tr>
<td><strong>Dept. of Social Services (DSS)</strong></td>
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<td>Jonathan Velez, MD</td>
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<tr>
<td><strong>Hartford HealthCare ACO</strong></td>
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Note: Representative from UnitedHealthcare/OPTUM is being identified
Working group norms - expectations for how we will work together

Objectives
- Develop recommendation for HIT infrastructure that serves as the foundation for care delivery and payment model

Presence
- Attend bi-weekly meetings with full group
- Participate actively in discussions to jointly shape work group thinking
- As needed, meet with facilitators one-on-one or in small groups in between workgroup meetings to move the answer forward
- Respond promptly to email and phone requests

Mindset
- Leave day job at the door, think of best interest of Connecticut
- Seek consensus amongst working group

Action
- Build momentum and excitement in your respective communities
- Champion this effort broadly
- Shape the future of health care delivery in Connecticut
Connecticut has a unique opportunity to address quality, access, and cost challenges today

Although Connecticut ranks at or above the national average on many indicators of health, there exists opportunity for improvement

- Connecticut is among the top five states with the lowest rates of smoking, premature deaths, and poor mental health days and the highest rates of immunization coverage; is among the top quartile of states with the lowest obesity rates; and is among the top 50% of states with the lowest rates of preventable hospitalizations, diabetes, infant mortality, cardiovascular deaths, and cancer deaths
- Health disparities, however, continue to exist across racial and ethnic groups, illustrated by the variability in the infant mortality rate of non-hispanic black infants that is 3x that of non-hispanic white infants
- Connecticut meets national average on select indicators of quality and patient experience, but quality varies significantly across regions

At the same time, Connecticut lacks a solution for the state to address the steep growth in state health expenditures

- Connecticut faces a potential ~$1B budget deficit in 2014 and 2015, driven in part by an increase in health care spending, which continues to grow at a rate higher than Connecticut’s gross state product
- Connecticut has the third highest per individual health care spend (including the highest per enrollee spend on Medicaid patients, 8th highest per enrollee spend on Medicare patients)
- Inefficiencies in health care utilization continue to exist today, illustrated by the significant utilization of high-cost care settings (e.g., emergency department) for non-urgent visits

While Connecticut has many payment and care delivery innovations underway, no common model is shared across Medicaid, Medicare, and Commercial insured populations

The funding and endorsement of the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Models (SIM) initiative provides a unique opportunity for key stakeholders within the community to address these quality, access, and cost challenges in a statewide, multi-payer collaboration
CT has support from CMMI to innovate care delivery and payment model reforms and has high aspirations for what it can achieve.

CMMI guidance for State Innovation Models (SIM) design states . . .

- Design care delivery and payment reform that touches **80% of state lives within 5 years**
- Roll-out across multiple payers’ populations in a truly **multi-payer approach**
- Describe how “**broad-based accountability for outcomes, including total cost of care** for Medicare, Medicaid, and CHIP beneficiaries, is created”
- Test innovative payment and service delivery models that have the potential to “**lower costs,**” while “**maintaining or improving quality of care**"

. . . helped shape Connecticut’s targeted aspirations

- Gain alignment around a common care delivery and payment model that is applicable across Medicare, Medicaid, and Commercial populations
- Define a solution that incorporates total cost of care accountability
- Maintain or improve leading indicators of health and patient experience under the new care delivery and payment model
- Establish timeline for rollout that will meaningfully curb health care spending growth within 3-5 years

SOURCE: CMMI Funding Opportunity Announcement, Connecticut SIM grant award letter
We will largely define and design the SIM care delivery and payment models by the end of July 2013.

**ROADMAP**

<table>
<thead>
<tr>
<th>April</th>
<th>May</th>
<th>June</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project set-up</strong></td>
<td><strong>Options and hypotheses</strong></td>
<td><strong>Design and planning</strong></td>
<td><strong>Syndication</strong></td>
</tr>
<tr>
<td>▪ Understand current state</td>
<td>▪ Identify target populations and sources of value</td>
<td>▪ Design detailed health care delivery system and payment model</td>
<td>▪ Draft testing proposal</td>
</tr>
<tr>
<td>▪ Establish vision</td>
<td>▪ Develop health care delivery system hypothesis</td>
<td>▪ Develop implementation and roll-out plan</td>
<td>▪ Syndicate with key stakeholders</td>
</tr>
<tr>
<td></td>
<td>▪ Pressure-test health care delivery system hypothesis</td>
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<tr>
<td></td>
<td>▪ Develop payment model hypothesis</td>
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<td></td>
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<td></td>
<td>▪ Align key stakeholders</td>
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</table>
The HIT work group will provide recommendations to SHIP, the primary decision-making body.
HIT will propose recommendations to the SHIP at regular intervals

ROADMAP

April
- 4/30 SHIP kick-off

May
- 5/20
  - Target sources of value
  - Options preview

June
- 6/10
  - Leading care delivery model option
  - New workforce and skill requirements

July
- 7/8
  - Detailed design
  - Workforce strategy
  - Community engagement plan

- 7/29
  - Care delivery roll-out plan

Care delivery

Payment model

- 6/10
  - Leading payment model option

- 7/8
  - Detailed design
  - Quality metrics

- 7/29
  - Payment roll-out plan

Health information and technology

- 7/8
  - Detailed requirements for infrastructure, linkages, and reporting

- 7/29
  - HIT roll-out plan
Work groups will work closely with each other to share insights

**Care delivery model**
- Care delivery model selection
- Optimal level of standardization across providers
- HIT support required to promote changes in behaviors, processes, and structures (e.g., data transparency)

**Payment model**
- Payment model selection
- Optimal level of standardization across payers
- Implications of HIT capabilities/infrastructure on payment model roll-out plan

**Health Information Technology**
- Implications of HIT capabilities/infrastructure on care delivery model implementation plan

- Metrics to support changes in behaviors, processes, and structures
- Behaviors, processes, structures to support under payment model
### SCOPE AND SCALE OF INNOVATION: CARE DELIVERY

The care delivery work group is considering focusing on a population-health model as the foundation for care delivery innovation.

<table>
<thead>
<tr>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population health</strong></td>
<td>Relationships with CT physician groups to support practice of evidence-based medicine and coordinated care, particularly for patients with chronic conditions.</td>
</tr>
<tr>
<td>Provider(s) responsible for the overall health of a population of patients over a set period of time and often targets highest cost group of patients with high touch care management.</td>
<td>Patient centered primary care program which supports access to primary care and enhances care coordination.</td>
</tr>
<tr>
<td><strong>Episodes of care</strong></td>
<td>Best practices created for discrete episodes based on national or local guidelines and enforced standard clinical protocols.</td>
</tr>
<tr>
<td>Provider(s) with direct or indirect control over majority of care delivery for a defined acute procedure or condition are responsible for all care associated with the procedure or condition (e.g., CABG).</td>
<td>Dedicated specialty hospital treats discrete eye procedures at lower costs and higher quality than in US.</td>
</tr>
<tr>
<td><strong>Discrete encounters</strong></td>
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<tr>
<td>Specialty or service specific providers with direct control over discrete components of care delivery.</td>
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</tbody>
</table>
# The care delivery work group is prioritizing 3-4 sources of value to target in the new care delivery model

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong></td>
<td>Prevention of disease by removing root causes</td>
<td>Smoking cessation</td>
</tr>
<tr>
<td><strong>Secondary prevention/ early detection</strong></td>
<td>Early detection of disease while asymptomatic to prevent disease progression</td>
<td>Breast cancer screening, Identification and management of patients at high risk for heart disease</td>
</tr>
<tr>
<td><strong>Selection of provider and care setting</strong></td>
<td>Utilizing highest value care settings and downstream providers</td>
<td>Phone consultation vs. in-person visit, Optimized specialist referrals</td>
</tr>
<tr>
<td><strong>Effective diagnosis and treatment selection</strong></td>
<td>Evidence-informed choice of treatment method/intensity</td>
<td>Reduction in inappropriate utilization of c-section</td>
</tr>
<tr>
<td><strong>Provider productivity</strong></td>
<td>Reducing waste at provider center</td>
<td>Improve flow in OR to increase number of surgeries performed daily</td>
</tr>
<tr>
<td><strong>Care coordination / chronic disease management</strong></td>
<td>Ensuring patients effectively navigate the health system and adhere to treatment protocols</td>
<td>Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)</td>
</tr>
</tbody>
</table>
While providers will be held responsible for total cost of care, the payment model work group is investigating complementary payment innovations.

**Scope and Scale of Innovation: Payment Model**

**GLOBAL PAYMENT**
- Full care continuum or sub-contracts w/ others
- Payment capabilities
- **Fully integrated** HIT
- **Larger** capital reserves
- Scale for proper risk adjustment, to reduce statistical variation
- **Advanced** data collection capabilities

**Upside Gain Sharing**
- Scale for proper risk adjustment, to reduce statistical variation
- **Moderate** data collection capabilities

**Downside Risk Sharing**
- Inter-operable HIT
- At least moderate capital reserves
- Scale for proper risk adjustment, to reduce statistical variation
- **Moderate** data collection capabilities

**P4P/PMPM**
- Scale for proper risk adjustment, to reduce statistical variation
- **Moderate** data collection capabilities

**FFS**
- Basic data collection capabilities

**Provider Requirements**

**Implications**
- Incentive to produce more without direct incentives attached to quality, efficiency outcomes
- Fewer disputes over data integrity, rules
- Smaller scale required for process measures
- Potential for increases in total cost of care, in spite of P4P
- Invites participation of providers who may not be fully committed to managing total cost and quality
- Limits participation to only those that are committed to managing total cost and quality
- Few providers currently capable of accepting
- Most likely to lead to changes in provider market structure

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1 For example, PMPM for care coordination
Core care delivery and payment innovation technology beliefs

- **Technology is a critical enabler** to any care delivery and payment innovation program
- Successful programs are iterative, focusing initially on quick-wins then rigorously prioritize implementation roadmaps based on capabilities and value potential
- Program and underlying technology design should take a provider-centric view to maximize adoption
- Technology solutions should not be the rate limiter on a payment innovation program
- Payers can significantly leverage and extend existing capabilities (e.g., analytics) to accelerate impact
- Robust vendor solutions are beginning to emerge and are a critical medium-term program component; plan to partner for the long-term to enable the deep integration required
- Focused change and adoption programs should accompany any technology deployments to drive impact
Key questions for the design of a supporting HIT infrastructure for care delivery and payment innovation

A. What capabilities are required across key stakeholders (e.g., payers, providers, community agencies) to implement the target care delivery and payment model?

B. What are the current HIT capabilities of payers and within the statewide infrastructure that are relevant to the new care delivery and payment model?

C. What is the optimal level of payer infrastructure standardization across each component (e.g., data, analytics, pooling, reporting, data visualization, portal)?

D. What is the best strategy to develop the required HIT capabilities?

E. What will be the pace of roll-out of the required capabilities throughout the state?

F. What is the required budget to develop these capabilities?

G. What is the best funding model to develop these capabilities?
Across payers and providers, there are four sets of capabilities required for care delivery and payment innovation.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Claims based tools</td>
<td>- Tools for payers to analyze claims and produce payment-related analytics, quality/outcome/performance metrics and make actual payments to providers</td>
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<tr>
<td>Provider portal</td>
<td>- Portal(s) for providers to access and submit information, data and analytics required to support care delivery and payment models</td>
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<tr>
<td>Care management tools</td>
<td>- Provider tools (e.g., workflow, event management) and analytics to e.g., physicians, care managers) coordinate the medical services for a patient (focus on highest risk)</td>
</tr>
<tr>
<td>Healthcare Information Exchange</td>
<td>- Integrated clinical data exchange among healthcare stakeholders (e.g., payers, providers), including the longitudinal patient registry that can be enabled by HIE</td>
</tr>
</tbody>
</table>
These four capabilities are often integrated into a typical solutions/capability architecture.

Healthcare Information Exchange (HIE)
- Admission/discharge data
- EMR-based clinical data
- Clinical patient registry

Care management tools (not exhaustive)
- Care coordinator workflow tools
- Event management based on clinical data (e.g., alerts)
- Steerage to 24/7 clinical access
- Communication support tools
- Telemonitoring, mobility, home monitoring tools

Provider portal
- PCMH enrollment
- Provider pooling tools
- Provider input into attribution / segment.
- Metrics capture (non-clinical and clinical)
- Reporting and data visualization

Claims based tools
- Population attribution and adjust.
- Population stratification
- Pooling analytics
- Claims patient registry
- Performance reporting
- Specialist / facility analytics
- Care gap analysis
- Event mgmt (e.g., alerts)
- Payment
Breakout exercise: What existing assets in Connecticut should we be aware of when designing HIT support for care delivery and payment?

- **Breakout:** Breakout into groups of 3 to discuss the following questions:
  - What **existing assets** in Connecticut can we leverage for the innovation of healthcare delivery and payment model?
  - How should these assets be leveraged in a **multi-payer** setting?

- **Group discussion:** Each group to report out synthesis for full team discussion
WHAT ARE THE CAPABILITIES REQUIRED?

A Impact achievable at each stage of technology maturity

Claims-based

- Implement program based on population analytics, pooling
- Risk stratify patients based on claims-based
- Understand current performance and key utilization / quality drivers using risk-adjusted performance reports
- Make informed referral decisions based on transparent specialist/facility data (e.g., quality, cost, patient experience)
- Evaluate / understand performance using web-based tools

Clinical data-based

- Coordinate care through EMR-integrated workflow tools
- Automatically prioritize care coordinator outreach and support with automated patient engagement
- Develop more accurate predictive gaps-in-care analytics

HIE-enabled

- Provide cross-provider longitudinal patient record to all providers at point of care
- Monitor patients continuously based on mobile-enabled devices (e.g., scales, glucometers)
**WHAT ARE THE CURRENT CAPABILITIES?**

**B Capabilities to be assessed through a set of structured interviews**

- We have developed a capability assessment tool and will need your input to complete the assessment:
  - Current levels of capabilities
  - Development approach (e.g., in-house vs. vendor)
  - Current initiatives/programs in flight
- An assessment needs to be completed for each payer

**Output will be used to inform cross-payer technology discussion and decisions**

**CAPABILITY**

- Population attribution and adjust
- Claims patient registry
- Performance reporting
- Specialist / facility analytics
- Care gap analysis
- Event mgmt (e.g., alerts)
- Payment
- Population stratification
- Pooling analytics
## Options for infrastructure/technology across multiple payers

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mostly consolidated across payers</strong></td>
<td>All payers using/sharing same infrastructure and technology</td>
<td>▪ Cost synergies from scales across multiple payers&lt;br&gt;▪ Reduced operational complexity and confusion for the users (e.g., provider portal)&lt;br&gt;▪ Foundational requirements for state-wide initiatives (e.g., HIE)</td>
</tr>
<tr>
<td><strong>Standardized but not consolidated</strong></td>
<td>Standardized output agreed-upon by all payers with independent execution and delivery</td>
<td>▪ Output consistency (e.g., payment calculation, quality metrics, provider reports) required for state-wide roll out&lt;br&gt;▪ Stakeholder complexities associated with shared infrastructure</td>
</tr>
<tr>
<td><strong>Not standardized or consolidated</strong></td>
<td>No standardization of output; no technology/infrastructure sharing or consolidation</td>
<td>▪ Cross-payer variation does not impact solution consistency&lt;br&gt;▪ Payers unable/unwilling to standardize</td>
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</table>
### Three core models to support care delivery and payment innovation technology and capabilities

#### Components

<table>
<thead>
<tr>
<th>Components</th>
<th>Coordinated</th>
<th>Standardized output</th>
<th>Shared infrastructure</th>
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<tbody>
<tr>
<td><strong>Payer capabilities</strong></td>
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<tr>
<td>Provider portal</td>
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<td>Data visualization</td>
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<td>Reporting</td>
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<tr>
<td>Claims-based tools</td>
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<td>Data</td>
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<tr>
<td><strong>Other capabilities</strong></td>
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<tr>
<td>Provider care management</td>
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<tr>
<td>HIE</td>
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#### Example options for standardization (not exhaustive)

- **A** Most technology diverse by payers
- **B** Unified provider-facing interfaces across payers
- **C** Shared/co-owned technology and infrastructure

#### WHAT LEVEL OF STANDARDIZATION ACROSS PAYORS?

- Mostly consolidated across payers
- Standardized but not consolidated
- Not standardized or consolidated
## Potential approaches to develop capabilities required

<table>
<thead>
<tr>
<th>Key options</th>
<th>Considerations</th>
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<tbody>
<tr>
<td><strong>Care management tools</strong></td>
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<tr>
<td>▪ Pre-qualified vendor/solutions</td>
<td>▪ Availability of payer-sponsored tool</td>
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<tr>
<td>▪ Payer-provider technology integration</td>
<td>▪ Differences between payers</td>
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<tr>
<td>▪ No payer support</td>
<td>▪ Provider adoption</td>
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<tr>
<td></td>
<td>▪ Integration with Provider IT/tools</td>
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<tr>
<td><strong>HIE</strong></td>
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<tr>
<td>▪ Leverage existing state initiative</td>
<td>▪ Scope and impact beyond payment innovation</td>
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<tr>
<td><strong>Clinical patient registry</strong></td>
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<tr>
<td>▪ Buy</td>
<td>▪ Existing capabilities and payer differences</td>
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<tr>
<td>▪ Build</td>
<td>▪ HIE maturity and roadmap</td>
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<tr>
<td>▪ Share existing</td>
<td>▪ Payer agreement to share information</td>
</tr>
<tr>
<td><strong>Provider portal</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Share existing</td>
<td>▪ Current level of multi-payer support/integration</td>
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<tr>
<td>▪ Integrate multiple portal</td>
<td>▪ Provider adoption</td>
</tr>
<tr>
<td>▪ Independent provider portal for each payer</td>
<td>▪ Complexity and investment required to integrate or share portal</td>
</tr>
<tr>
<td><strong>Claims based tools</strong></td>
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</tr>
<tr>
<td>▪ Buy</td>
<td>▪ Efficiency gain</td>
</tr>
<tr>
<td>▪ Build independently</td>
<td>▪ Complexity to feed data across different payers’ infrastructure</td>
</tr>
<tr>
<td>▪ Share analytics infrastructure</td>
<td>▪ Investment required</td>
</tr>
</tbody>
</table>
Technology planning is part of the overall population health program definition

**Stage 1**
- Primarily payer technology
  - Claims-based tools
    - Population attribution and adjust.
    - Population stratification
    - Pooling analytics
    - Specialist / facility analytics
    - Performance reporting
    - Payment
  - Provider portal
    - PCMH enrollment
    - Provider pooling tools
    - Metrics capture (non-clinical and clinical)
    - Reporting

**Stage 2**
- Payer and provider technology
  - Claims-based tools
    - Claims patient registry
    - Care gap analysis
    - Event mgmt (e.g., alerts)
  - Provider portal
    - Provider input into attribution/segment
    - Data visualization
  - Care management tools
    - Care coordinator workflow tools

**Stage 3**
- HIE-enabled, advanced payer/provider capabilities
  - Care management tools
    - Event management based on clinical data (e.g., alerts)
    - Steerage to 24/7 clinical access
    - Communication support tools
    - Telemonitoring, mobility, home monitoring tools
  - HIE
    - EMR-based clinical data exchange
    - Clinical patient registry
  - HIE
    - Admission/discharge data

**Core Technology**

**Description**

**WHAT IS THE PACE OF ROLL OUT?**

Illustrative
# HIT work group meeting and key decision cadence

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Objectives/decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st meeting</td>
<td>Understanding of HIT capabilities that will be required across key stakeholders under new care delivery and payment models</td>
</tr>
<tr>
<td>(5/20)</td>
<td>Criteria and approach to assess payer and health system capabilities</td>
</tr>
<tr>
<td>2nd meeting</td>
<td>Understanding of current capabilities and linkages of key stakeholders</td>
</tr>
<tr>
<td>(6/3)</td>
<td>Initial view on potential models for HIT standardization</td>
</tr>
<tr>
<td></td>
<td>Evaluation of required health data sources required under new care delivery and payment models</td>
</tr>
<tr>
<td>3rd meeting</td>
<td>Strawman for HIT standardization across key components</td>
</tr>
<tr>
<td>(6/17)</td>
<td>Options to develop required capabilities (e.g., public utility vs. proprietary solutions, build vs. buy)</td>
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<tr>
<td></td>
<td>Potential sequencing of required capabilities (e.g., feasibility, cost, day-one need)</td>
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<tr>
<td></td>
<td>Early assessment of costs of implementing required capabilities</td>
</tr>
<tr>
<td>4th meeting</td>
<td>Capability roadmap</td>
</tr>
<tr>
<td>(7/1)</td>
<td>Strawman budget</td>
</tr>
<tr>
<td></td>
<td>Assessment of potential funding sources</td>
</tr>
<tr>
<td>5th meeting</td>
<td>Finalized budget</td>
</tr>
<tr>
<td>(7/15)</td>
<td>Finalized funding sources</td>
</tr>
</tbody>
</table>
Set up one-on-one meetings in the next 2 weeks to:
- Understand current state infrastructure landscape
- Develop first hypothesis on infrastructure roadmap for SIM
- Assess gaps and identify options to close them
- Discuss potential challenges to be mindful of when determining strategy

Synthesize findings and prepare for next discussion on June 3rd
Appendix
### Going from “good” to “great” in technology for innovative care delivery and payment models (1/2)

<table>
<thead>
<tr>
<th>Category</th>
<th>What “good” looks like</th>
<th>What “great” looks like</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims based tools</strong></td>
<td>▪ Alignment across payers on analytics definition and reporting</td>
<td>▪ Pooling and analytics conducted across all participating payers for same providers</td>
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<tr>
<td></td>
<td>▪ Separate execution and infrastructure by payers</td>
<td>▪ Shared infrastructure enabling cross-payer pooling and efficient/ consistent analytics</td>
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<td></td>
<td>▪ Fully automated algorithm-based analytics</td>
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<tr>
<td></td>
<td>▪ Single-sign-on portal connected to payer-specific interfaces</td>
<td>▪ Centralized multi-payer portal that allows for cross-payer reporting, information exchange</td>
</tr>
<tr>
<td></td>
<td>▪ Static periodic reporting</td>
<td>▪ Dynamic reporting that allows providers to create drill-down analytics and customized reports</td>
</tr>
<tr>
<td><strong>Provider portal</strong></td>
<td></td>
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</tbody>
</table>
## Going from “good” to “great” in technology for innovative care delivery and payment models (2/2)

### WHAT ARE THE CAPABILITIES REQUIRED?

<table>
<thead>
<tr>
<th>Category</th>
<th>What “good” looks like</th>
<th>What “great” looks like</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care management tools</strong></td>
<td>▪ Care coordination playbook and tool selection criteria</td>
<td>▪ Tools provided/developed or certified by payers</td>
</tr>
<tr>
<td></td>
<td>▪ Alerts sent to providers through payer-specific channels</td>
<td>▪ Analytics, alerts and reminders fully integrated into workflow tools</td>
</tr>
<tr>
<td></td>
<td>▪ 24/7 access primarily through telephone</td>
<td>▪ Single multi-payer channel for alerts/reminders for providers</td>
</tr>
<tr>
<td></td>
<td>▪ Tele-monitoring on select high cost conditions (e.g., CHF)</td>
<td>▪ Multi-channel 24/7 access (e.g., phone, web)</td>
</tr>
<tr>
<td><strong>Healthcare Information Exchange (HIE)</strong></td>
<td>▪ Web-based tool that supports manual entry or upload of admission/discharge data and select clinical data</td>
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</tr>
<tr>
<td></td>
<td>▪ Real-time access to admission/discharge information (e.g., alerts)</td>
<td>▪ API-based real-time data exchange between payer and provider EMR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Centralized multi-payer clinical patient registry</td>
</tr>
</tbody>
</table>
## Example staged approach to roll out technology for innovation in care delivery and payment model

### SIM timeframe

#### Stage 1
- Primarily payer technology

1a. Population attribution and adjust.
1b. Population stratification
1c. Pooling analytics
1d. Specialist / facility analytics
1e. Performance reporting
1f. Payment

#### Stage 2
- Payer and provider technology

2a. Claims-based tools
2b. Provider pooling tools
2c. Metrics capture (non-clinical and clinical)
2d. Reporting
2e. Data visualization

3a. Care management tools
3b. Care coordina-tor workflow tools
3c. Clinical-data based analytics (e.g., care gap analysis)
3d. Steerage to 24/7 clinical access
3e. Communication support tools
3f. Telemonitoring, mobility, home monitoring tools

#### Stage 3
- HIE-enabled, advanced payer/provider capabilities

4a. Admission/discharge data
4b. EMR-based clinical data exchange
4c. Clinical patient registry
4d. Event management based on clinical data (e.g., alerts)
4e. Communication support tools
4f. Telemonitoring, mobility, home monitoring tools

### Description

- **Primarily payer technology**
- **Care management tools**
- **Provider portal**
- **HIE**
- **Claims-based tools**
- **Provider pooling tools**
- **HIE-based clinical data exchange**

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**Provider portal**

- **PCMH enrollment**
- **Provider pooling tools**
- **Metrics capture (non-clinical and clinical)**
- **Reporting**

**Care management tools**

- **Care coordina-tor workflow tools**
- **Clinical-data based analytics (e.g., care gap analysis)**

**HIE**

- **Admission/discharge data**
- **Event management based on clinical data (e.g., alerts)**
- **Communication support tools**
- **Telemonitoring, mobility, home monitoring tools**

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**HIE**

- **Admission/discharge data**
- **Event management based on clinical data (e.g., alerts)**
- **Communication support tools**
- **Telemonitoring, mobility, home monitoring tools**

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**Example**

CASE EXAMPLE

PROPRIETARY AND CONFIDENTIAL || PRE-DECISIONAL
Stage 1: Create separate payer reports and deliver through a common multi-payer portal

**Components**

**Payer capabilities**
- Provider portal
- Data visualization
- Reporting
- Claims-based tools
- Data

**Other capabilities**
- Provider care management
- HIE

**Stage 1 technology**

- Unified provider-facing interfaces across payers

**Stage 1 approach**
- Common portal across all participating payers
- Leveraging an existing provider portal and retrofit for multi-payer accessibility
- Standardized but separate reports for each payer
- All analytics, data and report generation technology different by payers with no consolidation

**Stage 1 timeline:**
- Year 1: Initial development and roll out
- Year 2-3: Addition of data visualization and more advanced functionality
Stage 2: Focus on developing care management tools for providers

Key elements to improve care managements

Options to address technology/infrastructure needs

- **Payers set clear functional requirements and request vendors to be qualified**
- **Providers select freely among qualified vendors**

**RFQ**

- **Payers develop care management tools (jointly or separately) and provide to providers**
- **Tools provided with no charge or charges to the provider (e.g., lower % of gain share, one-time fee)**

**Build/procure tools and provide to providers**

- **Payers set guidelines and/or requirements for care management tools and are not involved in providers’ selection, development or procurement of tools**

**No payer involvement**
Key questions to inform cross-payer technology design

<table>
<thead>
<tr>
<th>Category</th>
<th>Questions</th>
</tr>
</thead>
</table>
| Provider portal               | ▪ Are all payers willing to commit to a single provider portal for the SIM initiative?  
  ▪ If yes, is there currently a portal that all providers in the state have access to?  
    ▪ If yes, are all payers willing to use this portal?  
    ▪ If no, which option should we take to have a single portal? A) Build, B) Procure, C) Revise an existing website, D) Other? |
| Data visualization            | ▪ Are payers willing to store all raw claims data in the same data store?  
  ▪ Are payers willing to co-invest in developing shared data visualization capabilities? |
| Reporting                     | ▪ Will there be a single report across payers or separate reports?  
  ▪ If separate reports, will the reports be highly standardized? |
| Claims-based tools            | ▪ Do payers currently have the capabilities to perform claims analyses required by the target payment model? |
| Data                          | ▪ Is there an existing multi-payer database?  
  ▪ If yes, are payers willing to build shared analytical capabilities for this database?  
  ▪ If no, is there a plan to develop one during the SIM timeline? (~36 months) |
| Provider care management      | ▪ How are payers assisting providers in care management technology today?  
  ▪ Are payers willing to co-invest in a single solution for care management? |
| HIE                           | ▪ What % of population/patients are currently covered in HIE? |