STATE OF CONNECTICUT
State Innovation Model
Health Information Technology Council

Meeting Summary
Thursday, December 18, 2014

Members Present:
Dr. Thomas Agresta, Dr. Anne Camp, Dr. Patricia Checko, Dr. Anthony Dias, Mr. Ed Fisher, Dr. Michael Hunt, Ms. Vanessa Kapral (via phone), Mr. Matthew Katz, Ms. Theanvy Kuoch, R.N., Mr. Michael Michaud, Mr. Mike Miller, Mr. Mark Raymond, Mr. Philip Renda, Ms. Jenn Whinnem, Mr. Josh Wojcik and Mr. Moh Zaman

Members Absent:
Commissioner Roderick Bremby, Ms. Crystal Emery, Dr. Alan Kaye, Dr. Stephen O'Mahony and Dr. Craig Summers

Other Participants:
Dr. Mark Schaefer, Dr. Minakshi Tikoo and Ms. Fran Turisco (facilitator)

Meeting was called to order at 1:05 p.m.

1. Introductions
Mr. Mark Raymond chaired the meeting and all participants introduced themselves.

2. Public comment (1:14)
There was no public comment.

3. SIM Initiative Overview Presentation (Mark Schaefer) (1:14)
Dr. Mark Schaefer provided an overview of the State Innovation Model (SIM) program. CMMI was established as part of the Affordable Care Act. (ACA). SIM is a more ambitious initiative than many of the others done in the past (e.g. bundled payments). SIM issued a challenge to states to develop approaches to move the reform agenda forward.

Connecticut (CT) participated in Phase I as a design state, not a test state. CT undertook a planning process using $2M CMMI design grant. The state used triple aim as a foundation and added its own customization, specifically to focus on health inequities, care experience, active participation of individuals in healthcare.

CT's initiatives are twofold: broad (anyone can benefit) and targeted (test systems in a focused way to accelerate advancement).
Reviewed initiatives:

- Population health. Dr. Schaeffer described determinants of health that include genetics, social circumstances, behavioral choices, environmental condition and medical care. He also described the shared vision for care transformation from acute to coordinated community integrated healthcare.
- Payment reforms. This aspect was central to CMMI criteria. Healthcare must migrate from fee for service (FFS) toward value-based care (VBC). Dr. Schaeffer described the spectrum of VBP, stating that Medicaid will only use upside gain-sharing. Today there are13 provider

organizations that are participating in Medicare Shared Savings Programs (MSSP) as ACOs in CT. In addition CT FQHCs are seeking opportunities to take accountability for quality and total cost of care (Q&TCC). Medicaid participation will help them develop their capabilities, and will enable advanced networks to have VBC be the predominant form of payment.

There are several opportunities to align with MSSP. The state has prioritized quality measures, starting with the MSSP measure set. CT will supplement the set with its own measures (e.g. for patients <65 population) and accelerate toward outcomes-based measures. Currently Medicare is the only scorecard nationally that has a majority of measures that are EHR-based vs. commercial plans that use 100% claims-based measures. In addition, measure alignment will overcome small sample size problem for certain conditions.

- Role of HIT Council. There are two important early goals: (1) Recommend solutions to enable data collection for performance measurement such as edge server, and APCD and 2) Enable exchange of information across providers using direct messaging and provider directories.
- Value Based Insurance Design (VBID). The goal for this program is 85% penetration by 2020.
- Medicaid Quality Improvement Shared Savings Program (MQISSP). DSS will procure FQHC and advanced network participants to participate. Selection is based on abilities and >5,000 single-eligible Medicaid members. The adoption will be done in waves.
- Advanced Medical Home (AMH) glide path is targeted to practices affiliated with advanced networks. CT will offer the ability to fill the gaps to get from Patient Centered Medical Home (PCMH) to AMH.
- Community & clinical integration will enable the enterprise using targeted technical assistance and learning collaboratives.

In the SIM governance organization review section of the presentation Dr. Schaeffer stated that all councils have been stood up except for the Work Force Council. All councils have representatives from patient advocacy, clinical, payer and employer groups.

Matthew Katz asked about the project duration. Dr. Schaefer responded it is 3 years and 11 months. Pre-implementation is planned for 2015. Implementation starts in 2016, and continues into 2017 and 2018. Ideally the state wants to put in place as much of enabling architecture as possible for 2016. However, the HITC might decide that certain things need to be staged.

As an aside, Michael Michaud thanked a number of people for their work on the grant: Lt Governor Wyman and Dr. Schaefer for their work. Only 11 states won. Dr. Schaefer thanked the volunteers and state agency partners for volunteering their time.

Dr. Camp clarified that this initiative is intended to cover the entire state, including the uninsured. Dr. Schaefer said yes. CMMI views the denominator as the state population. Dr. Schaefer acknowledged that primary beneficiaries of payment reforms will be the insured, but that the uninsured will benefit from systemic focus on care experience and outcomes. Dr. Camp suggested that if we are trying to move the whole state forward, we need to acknowledge the uninsured since they move in and out of that status, and cost the state money.

4. HIT Plan Overview (as it relates to SIM) (1:45)

Mr. Raymond reviewed the HIT plan. The list of technology components represent the minimum set. These include:

- CareAnalyzer – predictive modelling
- HIT Strategic Plan. Called upon by statute this year.
- APCD – All Payer Claims Database.
- Consent Registry to track individuals' consent to share information.
- Disease Registries.
    - Matthew Katz asked about MU2. MU2 for physicians requires the EHR to access a statewide disease registry. CT is one of a few states without statewide registries. Mr. Katz concerned about MU investments being wasted if state isn't up to speed with technology for provider to meet the requirement to connect to a state agency database.
    - Vanessa Kapral said that DPH has run out of money for MU as of March.
    - Dr. Tikoo added that according to the MU requirements, if state hasn't stood up the resource, providers are not penalized. She agreed that registries are important but noted that we need to see how much money we have for it. The council needs to make sure we focus the money on the SIM initiative.
    - Dr. Schaefer described an intent to use a non-traditional approach toward disease registries, e.g. crowd-funding.
    - Mr. Raymond acknowledged that funds beyond SIM will be needed for some additional technology purchases, and members will need to look for other funding sources.
- Crowd-sourcing – social media solutions that collect input from a group of knowledgeable sources
- EMPI – enterprise master patient index
- Personal health record
- Provider registry. Understanding in a non-duplicated way what providers are in the state.
- Direct messaging. Especially for transitions in care.
- Edge servers. Dr. Tikoo provided an overview of the edge server technology. Noted that the vendor presented at the HISC and will present to the HIT.
- EHR service as software.

A subset of HIT initiatives are part of SIM (bolded items) in the presentation.

HIT Governance. Starting 10/15/14, the group was schedule to hold a set of six planning meetings. Three occurred and the other three should take place in 2015. The plan will operationalize the cross-agency governance structure that brings together and builds upon initiatives from last four years with respect to health and human services.

SIM HIT Plan Budget. Mr. Raymond reviewed the SIM HIT budget. CMMI was clear that it would not invest in all new technology. Rather, the expectation was for the state to leverage existing technology and programs and for the SIM to fill in the HIT gaps.

Pat Checko asked about state funding source within budget. Dr. Tikoo responded that funds are from bonds, not from DSS budget.

Jenn Whinnem asked about the reason for costs if the state is already using the application. Mr. Raymond responded that costs include standing up, integrating, scaling up, or additional licensing capabilities.

Phil Renda asked about EHR as software as a service. Dr. Tikoo responded that the goal is to provide access to those who don't have EHRs.

Anthony Dias asked about CareAnalyzer. Dr. Tikoo responded that this is a predictive modeling product that uses The John Hopkins algorithms. Dr. Schaefer elaborated that CareAnalyzer is a tool that the Medicaid ASO uses for risk stratification within its population.

A question was raised if the state programs were duplicating any of the technology solutions. Specifically, in the HISC, there is concern that advanced networks are developing their own capabilities – is this duplicative of what they are building? The response was that members need to strike the right balance and that's why we have ACO representatives on the Council.

Mr. Michaud asked about the APCD. He thought that it was moving forward without SIM funds so why is there a line item for additional cost. Dr. Tikoo responded that the cost is for scaling it up for the additional lives.

Phil Renda asked for an update on APCD. Mr. Katz noted that the vendor has been selected. In 2015 it will be loaded with claims data. By the third quarter next year the data base should be up to date. The timeline will depend on required changes. If the SIM group has suggested changes or requirements, we should let the vendor know as soon as possible. Mr. Michaud noted that APCD vendor has already collected 36 months of data.

Overall, the question was raised if there was a need to debate each of the individual items now or will the council go through them later? The answer was this meeting was just to provide an overview; the council will be reviewing the technologies as part of their charge over the next five months.

Ms. Checko asked for background explanation on why we've chosen to follow the Medicare model rather than looking at other approaches. Dr. Schaefer responded that much of the technology is designed to enable activities in the field that will help us achieve our cost and quality goals, e.g. the consent registry is not a Medicare tool. It will help performance for Medicare enrollees and for others.

Mr. Raymond added that during the planning phase we followed a process to determine what was required to deliver the outcomes. Then we assessed what was doable during the timeline of the grant. There was a scaling back of what could be done within the time period of the grant. We collected input from the four constituencies during that process as well.

Ms. Kuoch noted that 500,000 CT residents are foreign-born. A substantial number are English-speaking limited. Is HIT going to collect data on underserved or vulnerable populations? Dr. Tikoo responded that from an HIT perspective, the organization collecting the data will have those capabilities in place. One of the things we could do is assess whether that is in fact being done.

Dr. Thomas Agresta commented that a central challenge we will have is that these are all centralized IT resources. At the same time as we are trying to build these resources centrally, providers are moving ahead with their own investments. Mr. Raymond noted that we will be trying to leverage and account for those resources that are being developed.

Dr. Hunt noted that the list two components (1) medical services (2) medical management. We should think about how to categorize the items.

5. Questions and Clarifications
There were no further questions or clarifications at this time.

6. Meeting Ground Rules (2:25)
Fran Turisco introduced the purpose of this section of this agenda; specifically to level-set meeting participation with everyone. Ms. Turisco noted the group's expertise and the importance of attendance. The group will leave titles at the door and attempt to operate by consensus in the best interest of the state of CT.

Although there were no objections to the ground rules, Mr. Katz asked for the materials to be provided ahead of time so the council members can prepare questions in advance. Ms. Turisco agreed. This will be part of the group's schedule moving forward.

7. DRAFT Charter Components (2:32)
Ms. Turisco discussed the major components of the council's charter – purpose, goals, scope, roles and responsibilities and decision making. She reviewed the purpose, goals and scope. At that point Dr. Agresta asked about personnel and skills required to implement solutions; don't just focus on the technology.

Ms. Checko noted that we are talking about mechanics rather than about the data. Discussed role of income, education, patient behavior – are we taking these into consideration?

Mr. Michaud noted that in the design phase each meeting started with an update on what other groups are doing. This would be helpful for this group. Also would be helpful to include updates on related IT initiatives.

Mr. Katz suggested that we should spend more time on the charter. What is the direction and status?

Dr. Schaefer suggested that we have a task force on the charter development. Mr. Katz volunteered. Ms. Turisco will take the points from the presentation and transfer them into a draft charter document that will be reviewed by the task force. Note: Ms. Turisco will review with the other council members during the next few weeks so a final draft can be brought forward at the next meeting.

8. Approach and Near-Term Steps (2:45)
Ms. Turisco reviewed a draft timeline and approach for the council's work.

Ms. Checko asked how we relate to the larger agency HIT governance structure. Dr. Schaefer responded that it is premature to define the relationship precisely. CMMI requires CT to have specific, broader plans for governance in two areas: (1) population health and (2) HIT.
Dr. Tikoo noted that HIT strategy will be underway by late spring 2015.

Mr. Raymond noted that this was discussed at yesterday's HIT governance meeting. The answer is not known, yet but it needs to be addressed. He clarified that the HIT plan needs to account for what we are doing in SIM. The two initiatives are mutually reinforcing but not completely overlapping.

Dr. Schaefer noted that the HIT Council, in addition to considering the funded projects, can consider opportunities associated with other needs (e.g. providers needs from payers) that might have a broad-based state-negotiated solution.

Next Steps

Ms. Turisco talked about the immediate next steps – the consent registry and data collection technology analysis and asked for volunteers.

Consent Registry- Dr. Hunt and Moh Zaman volunteered to participate in consent registries. Mr. Michaud suggested we talk to Access CT Health regarding its Au Pair database. A phone participant also volunteered but did not identify himself.

Data Access Technologies: Mr. Katz, Mr. Renda, Mr. Fisher and Dr. Dias volunteered.

Charter: Mr. Katz and Dr. Checko volunteered.
Ms. Checko asked whether we can seek input from others outside the committee. The answer is yes.

The group asked if Deanna would send out a participant list that included email addresses and other contact information so the smaller groups can get time scheduled for conference calls and meetings.

9. Meeting Logistics (3:01)
Ms. Turisco presented meeting dates and schedules for distributing information. She noted that end of June is end of Phase I. The process will continue after that.

Ms. Camp requested that conversations be public, not on the sidelines, to the extent possible.

Dr. Schaefer noted that the meeting materials will always be posted online.

Mr. Katz asked if there is a comprehensive inventory of HIT systems currently employed by the state as reference. Mr. Raymond said no, but it may be done. Mr. Katz suggested that it be done.

Mr. Katz asked when the PMO employees start. Dr. Schaefer noted that he is beginning to hire with separate funds and that Chartis is filling the gap for the moment. Dr. Tikoo is ramping up her staff more aggressively. The HISC also asked about pace of hiring so Dr. Schafer suggested that both groups are kept informed on this topic. Ms. Checko asked about any impact of the freeze. Dr. Schaefer is hopeful that OPM will permit these hires but that it will make those decisions on a case by case basis.

The meeting was adjourned at 3:07pm.