Annual Implementation Advance Planning Document (FFY18-19 IAPD)

Summary of Comments

The following is a compilation of feedback received for the CT Department of Social Services request for Centers for Medicare and Medicaid (CMS) funding for federal fiscal year 2018 – 2019.

➢ The hiring of the State Health Information and Technology Officer to coordinate the state's health information technology initiatives and oversee the development of a state health information exchange was an exciting and important step forward. Too much of the state's efforts were based on short term agency specific goals. Also, too often the state did not include stakeholders or build confidence in and support for our efforts. The recent stakeholder engagement process has begun to turn the tide and build the cross stakeholder support we need to build a statewide coordinated value based HIE system. I am happy to see funding for the HITO included in the IAPD. This effort is critical to moving the state forward. I believe it is important that the Medicaid Enterprise Provider Registry and the Project Notify: (Medicaid Alert, Discharge, Transfer) as well as the Statewide HIT strategic plan be done in collaboration with the HITO and consistent with the state's HIE development plan. I am puzzled and concerned about the proposed use of ZATO. The Advisory Council expressed serious concerns about Zato's qualifications in this area and voted not to proceed with a ZATO pilot. Instead, the Council wanted to solicit other RFPs to compare vendor proposal, capabilities, etc. Proceeding with Zato without the Council's support and not in consultation with the HITO seems short sighted and unwise.
➢ I am pleased to see that Appendix D includes funding for the state Health Information Technology Office. I believe this position is key to both the implementation of the state Health Information Exchange and to ensuring the organization and use of the state's health information technology across platforms and agencies It would also seem to me that the Medicaid Enterprise Provider Registry and the Project Notify: (Medicaid Alert, Discharge, Transfer) as well as the Statewide HIT strategic plan should be done in collaboration with the HITO and HIE. I am concerned with the use of ZATO which was never approved by the HIT Advisory Council. In fact, the Council expressed numerous concerns during several meetings and voted not to proceed with a ZATO pilot, but rather to gather other RFPs. It appears that the department has simply ignored the views of the council and decided to proceed with ZATO

without any collaboration with the Council or the HITO.

- The current IAPD funds various initiatives through September 2019. Although it is relatively late to entertain this idea, wouldn't it be in the better interest of the State to include funding for interoperability and governance planning with the Connecticut State Medical Society's (CSMS) Health Information Network? Michigan (and possibly other states) faced a similar challenge -- integrating with one or more existing "sub-state" HIEs. Planning for this integration as early as possible might be strategic. Waiting for two more years before explicitly funding this endeavor might make our work much harder. Michigan's MiHIN Strategic Plan (http://www.michigan.gov/documents/mdch/1796_07_01_10_333525_7.pdf) provides an adaptable framework for the kind of interoperability with CSMS that we may need. For example, on pages 31-32 of the MiHIN Strategic Plan, Michigan lays out a set of criteria that all sub-state HIE's must meet to be part of the statewide health information network. On subsequent pages, Michigan describes how interoperability on a national level would be channeled through MiHIN. In their architecture, MiHIN holds the official statewide master patient index and provider directories, and they also provide a security framework for the statewide network. An initial interoperability planning effort involving CSMS could address these concerns.

  We didn't really have a responsible methodology for reviewing the budget. We examined the budget and staffing plan for the State of Michigan's MiHIN (http://www.michigan.gov/documents/mihin/MiHIN_Shared_Services_Operational_Plan_4-30-10_320163_7.pdf , see pages 18-23) and noted the existence of several positions (most notably, technical positions) that are not represented in our IAPD. We recognize that the scope of the current IAPD is considerably more focused than MiHIN's strategic and operational plans and does not include certain technical positions that are funded through one or more separate IAPDs (or the State's general fund, ... etc.). Nevertheless, it might warrant another table or at least a footnote to represent those positions that support the current projects but are separately funded.

  We have some minor comments, as well:

  - For Goal 2 Project 3, doesn't the acronym ADT typically stand for "Admit, Discharge, and Transfer," rather than "Alert, Discharge, and Transfer?"
  - In Table 6, in the row for DSS Enterprise Project Management Office, should we include the project management support for BISA (per page 12)?
  - In Appendix A, the MMIS Related Expenditures are constant across the two fiscal years. Does HHS/CMS have a 0% inflation fiscal policy?
  - Appendix E indicates that the MITA state self-assessment is ongoing with a projected completion date in May. This statement should be updated before submission.

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Continue to improve information exchange by enhancing interoperability hub for Medicaid using Direct Messaging services via the MEDS Project: The Secure Transport of Electronic Prescriptions of Medicaid Equipment and Supplies (MEDs)

***Comment**: What does this entail? If it is not embedded within the Clinician Workflow it will be problematic to deploy.*

Continue to improve outcomes for Medicaid recipients utilizing Alerting via Project Notify: The Medicaid Alert, Discharge, Transfer Notification System

***Comment**: Is there anyone using this system at this point? If so who and what are the outcomes / issues to date?*

Continue to encourage and assist providers to submit eCQM data using QRDAs 1 and/or to our popHealth certified solution in the Zato Health Platform

***Comment**: Is it possible that DSS will require Medicaid EH and EP's to use the Zato platform to meet the Meaningful Use program requirements? If so this needs quite a bit more evaluation / testing etc..*

Expanding the use of Personal Health Records to Medicaid recipients beyond Long Term Services and Support populations in FFY19 thus assisting Medicaid Electronic Health Record Incentive Program participants to meet Meaningful Use patient-centered measures. (Stage 3 EP measure 5 – Patient Electronic Access)

***Comment**: Is this implemented for anyone? If so whom and what are the outcomes and where is the demonstration of how it works / who it serves?*

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In parallel the Department has continued to establish the network-of network model and will complete the build and implementation of the Medicaid node using the Intersystems platform.

***Comment**: what does this look like? What information will be capable of being shared / received?*

Connecticut plans to submit an IAPD update later this year for additional statewide HIT/E planning and implementation activities, once the initial planning efforts are completed by 4th Quarter FFY 2017

***Comment**: Ok – good there is a specific plan for an IAPD update mentioned*

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Secure Transport of Electronic Prescriptions of Medicaid Equipment and Supplies (MEDs) - Onboard Physicians and MEDS providers

***Comment**: This is the first I am seeing this – I would want to understand this quite a bit better prior to making more formal comments – but I have some concerns as to how well this will work*

Medicaid Enterprise Provider Registry

__Comment__: How will this (if at all) connect to a state-wide HIE effort? Would it simply by the Medicaid Registry

Page 8:

Under Goal 2 Project 1

<u>Enhancements to web based MEDS prescription forms configured to the CT domain</u>: Enhancements to the unique MEDS prescription forms are needed to expand for both providers in the CT Direct Domain and providers outside the domain.

<u>Provider and MEDS Provider Education and Onboarding Support</u>: SES will need to ramp up outreach, enrollment, verification and training to MEDS project participants post beta-testing phases to ensure effective implementation of the project.

__Comment__: Does this mean that a web-based format for entering these prescriptions will be required? If so it would be out of the usual workflow for a clinician and could be problematic. This would be a very good program to have described to the HIT Council to see if it could be better incorporated into the state Interoperability approach and if possible ordered directly from the EHR's

Under Goal 2 Project 2
Completion of Phase 1 will ultimately make the EPR available to other ASOs and State agencies as a shared service.

__Comment__: Would this also mean it would be available as a shared service to the State Comptroller's office for example to help in its Value Based Insurance programs? This would require its use beyond Medicaid patients and providers.

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Goal 2 Project 3: (Continue) Project Notify Needs: The Medicaid Provider Alert, Discharge, Transfer (ADT) Notification System Program

__Comment__: This is duplicative of efforts such as Patient Ping and a side-by-side evaluation of the use, options and costs of both systems should be considered as it is unlikely that clinical organizations will participate in both if is optional.

Page 10:

Under Goal 2 Project 4
Additionally, the Department aims to enhance the PHR with a Personal Health Assistant application within the PHR that supports people making better health choices based on interactive and preferred criteria set by the person.

***Comment**: IT would be good to see a demonstration of this project as well as get some data about use ad challenges encountered. I find it hard to imagine that a PHR without a connection to multiple EHR's where a patient might receive care would be of much benefit. In addition, some EHR vendors are developing PHR like settings for their patient portals – in essence allowing multiple different portals (from say several EPIC institutions) to be aggregated in one location. Not sure where the long-term game here is for either approach but this should be debated / explored) Usability will be a big issue with these efforts as well.*

Under Goal 3 Project 1
The Department intends to reuse and leverage Zato Health Platform (ZHP) as one of the base solutions for indexing all of the Department's data. An added benefit is that ZHP is ONC certified by the Open Source Electronic Health Record Alliance (OSEHRA). Currently, ZHP passed all 93 c3 items (CQMs) in internal testing from local copy of Cypress. The system passed the CQM measure portion of the InfoGuard certification testing on March 1, 2017. OSEHRA mapped internal engineering quality management procedures to ISO 9001 so that the 5.0 version of popHealth will result in certification for the applicable criterion. This will enhance our ability to take QRDAs to process the selected eCQMs being submitted by Eligible Professionals. Additionally, the Department will leverage this methodology to collect other standards-based clinical quality measures for other initiatives.

***Comment**: This needs further explanation to better understand what is being proposed and the actual software platform being proposed. How this will interact with other components of the HIE state plan should be described over time. In particular it is not probably logical to have several eCQM solutions as this will diffuse the time, energy and money required to set up and maintain the infrastructure. In some initial demonstrations of ZATO to the HIT Advisory Council to the SIM they did not adequately show that they had accomplished this in a reliable fashion. It is possible that this was not an adequate demonstration or that there has been significant development since that time. A follow up would be advisable if DSS will be using this approach and planning on getting their own eCQM's. It might not be inappropriate to "pilot" or try two or more solutions with willing partners to rapidly get feedback on how well they work for predicated purposes.*

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Comment: Overall this section is clear and well written albeit somewhat limited in detail. There are only a few comments as noted below.

…including a statewide eCQM reporting and measurement solution.

Comment: This statement and the prior ones related to Medicaid eCQM (with a specific vendor named) are discordant with each other and if I was the reviewer at CMS I would ask for clarification.

Page 28:

Coordinate with Medicaid, the Office of the State Comptroller's, and other state and private efforts to support the State's priorities to accelerate the development and use of key HIE utilities such as an electronic clinical quality measurement solution, components of the technology stack and to identify additional health IT needs and priorities that will emerge from the 2017 stakeholder engagement and environmental scan.

Comment: *Should the other potential planning options also be included such as the Immunization registry and Disease Surveillance systems also be included?*

Page 2:

Continue to encourage and assist providers to submit eCQM data using QRDAs 1 and/or to our popHealth certified solution in the Zato Health Platform

Comment*: Does the state own this? Please discuss the Zato cost?*

Expanding the use of Personal Health Records to Medicaid recipients beyond Long Term Services and Support populations in FFY19 thus assisting Medicaid Electronic Health Record Incentive Program participants to meet Meaningful Use patient-centered measures. (Stage 3 EP measure 5 – Patient Electronic Access)

Comment: *What Personal Health Record exist for it to be expanded? Please explain the use of PHRs to assist EHR Incentive programs participants MU measure? The MU is that provider patients use the EHR systems patient portal, correct? So please explain how a new PHR will assist with the MU.*

The Design, Development, and Implementation of a Business Intelligence and Shared Analytics Solution supporting continued development of quality improvement initiatives within Medicaid. (Stage 3 EP measure 6 – Coordination of Care and Clinical Quality Measure Reporting)

Comment*: Can we understand what currently exist that will be used to continue development? Please also provide the improvement initiatives and how these are being used and measured? What platforms is this built on?*

Page 3:

Between 2014 and 2016 the Department of Social Services was charged with leading the state Health IT and HIE agenda. Over a period of two years much work was completed by the department to establish a governance and a statewide HIE plan by the DSS Commissioner guided by the PA 14-217 and PA 15-146.

Comment*: I thought it was the HITO. What is this plan and how was it developed?*

Page 5:

Table 1: Activities under SMHP and IAPD

__Comment__: All documented requirements should be provided to understand how these have formed from initiation.

Page 6:

The following section represents an update of the Medicaid HIT Program's needs and includes a new funding request to further advance the Department's Business Intelligence Competency Center (BICC) that was established in 2014.

__Comment__: This statements makes it seem like BICC exists and is looking to be further advanced. Please provide what this is and look at all documentation to understand how it was formed, who the users are, the users systems, how the system is used, and the user feedback as this is the foundation for BISA. Please explain?

Page 7:

Pre-Payment Review: Ongoing pre-payment reviews of EPs/EHs attesting to the Program via MAPIR are needed. The review process has been automated affording standardization in review and payment authorization. Enhancements to the automation would further support increased efficiencies and accuracy in reviews.

__Comment__: This is being done by UCONN?

Page 8:

Goal 2 Project 2 Medicaid Enterprise Provider Registry Program Needs

Comment: Similar to above comments on documentation and how being used? What is the goal of having a separate provider registry instead of creating a provider domain in the MDM system, EMPI?

<u>Relationship Registry</u>: The Purchase and implementation of the NextGate Relationship Registry enabling the development of additional use cases as an enterprise-wide asset and for Phase 2 development.

__Comment__: Why is this required? And why NextGate as there are other systems or ways to do this using analytics to conduct patient provider attribution that provides dynamic configuration?

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Goal 2 Project 3: (Continue) Project Notify Needs: The Medicaid Provider Alert, Discharge, Transfer (ADT) Notification System Program

Comment: How does this differ from 'Patient Ping' that some providers have already signed up with?

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<u>*Goal 3 Project 1:*</u> Business Intelligence and Shared Analytics (BISA) Solution Program Needs – Zato Health Platform

> ***Comment****: Was an RFP done before deciding on the use of this vendor for this task?*

Page 12:

<u>Contractor Analytics Personnel:</u> Contracted staff to conduct analysis from the BISA on behalf of the Department.

> ***Comment***: Why is this going to be contractors instead of leveraging the state resources that have been brought in to define and design advanced analytics solutions within the healthcare industry? These are skills the state should be building at the state wide level and not skills we become more reliant on contractors.

<u>BISA Program Objectives</u>:

> ***Comment***: How did BICC support these that a new solution is required with the same requirements?

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The BISA request, as described in Section 3, is favored over two other alternative options

> ***Comments:*** *How is the solution above better then these alternatives? What other state is using the approach above as well as the technology?*
>
> *Can DSS provide more details into why Alternate consideration is cost prohibitive*
>
> *For Alternate Consideration 2, How and what systems are units currently using and what best in breed technology do they use?*

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Table 6

DSS Enterprise Project Management Office

> ***Comment****: Is this DSS state staff or HTS? Is there a conflict with HTS being EPMO and staffing the projects as well? If HTS, what detail do they see in contracts?*

Relationship Registry

Comment: How would this be done that it is seamlessly created? Need more documentation as to the requirements to purchase a silo'd system like this.

Business Intelligence Shared Analytics & eCQMs

***Comment**: Can more detail be provided as to the existing tools and who is using them? Also above it mentioned that DSS owns this system, so what are the dollars here used for?*

Patient Health Record

***Comment**: What PHR system was implemented and how used?*

Integration Platform

***Comment**: So HIE software has been purchased? Where is the documentation requirements and designs, etc….?*

Technical and Analytics SME

***Comment**: Who is this and what SMEs and experiences? This is very vague.*

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Incorporate the EHR Incentive Program into the Department's Enterprise

***Comment**: What DGO exists and what is the umbrella charter? DGO's provide the DG policies that are to be followed as best as possible.. putting a project or operations under DGO is not following DG practices. Just confusing as to the reason to establish DG as a project control.*

- In review of the subject document, nothing jumped out at me of concern prior to our meeting tomorrow. In reading the materials and after meeting with Allan, I'm curious to see how the EHR implementation over the next year ties in with what will happen state-wide.

- I am new to this committee and I am apprehensive to comment because I may not be fully understanding what is being proposed but this is what I think I'm seeing. I didn't realize the HIE/HIT activities were eligible for the 90/10 federal funding. I think I recall when this generous federal funding reimbursement percentage was initially introduced, it was for a time limited period and then it would be reduced back to the traditional levels. If we are near that deadline, I'd suggest a much more aggressive implementation schedule to make sure the project was significantly completed prior to the reimbursement rate changing. Since the reimbursement rate is so high the cost to the State is marginal at this point, to bring on more staff/contractors to get this done quickly. I'm afraid it will only get more expensive if delayed. Considering the CedarBridge report that indicated that Connecticut was much further behind in establishing a HIE than our neighboring states, the only reason not to act swiftly was the ability of the State to support the necessary funding. This is less of an issue at this reimbursement rate.

  My only comment would be if we aren't asking for everything we need to move this project along quickly, I think that might turn into a lost opportunity.

- On goal 1, I would consider suggesting using current available data to better inform the education and outreach. The section does indicate some of this but I think greater detail and specificity here would be valuable. For example, can DSS identify all providers who have not attested, ever, once, S1, S2 and develop an individualized engagement and outreach strategy to the particular groups by specialty or setting? The Incentive program is quite mature at this point but many providers still have special needs that need attention to in order to fully participate. At this point in the process, I believe this should be DSS primary focus in this goal.

  On goal 2 Project2, I question why completion of Phase 1 is to ultimately make the EPR available to ASOs and State agencies and not other organizations. Perhaps these are the only use case scenarios.

  On goal 2 project 3, I believe objectives should include some utilization goals.

  As a general comment, I find the objectives on all goals lacking concrete measurements of success. Again, this may be my misunderstanding of the documents purpose and be completely appropriate.

  On goal 3 project 1, I believe an objective should be to align this particular project with the state wide eCQM project as referenced in the appendix D.

  In regards to Appendix D, it's not clear how, if, when and if it even should, integrate with the IAPD other than the statements on the Inter-Agency MOA. The first 2 paragraphs on page 3 of the IAPD could be a good place to elaborate further or perhaps just say, see appendix D.