Health Information Technology Advisory Council

Meeting Minutes

Meeting Date	Meeting Time	Location
February 20, 2020	1:00 pm – 3:00 pm	**Webinar Only:** Call-in: +1 646 876 9923 US (New York) or +1 669 900 6833 US (San Jose) Meeting ID: 915 903 919 https://zoom.us/j/915903919

Council Members					
Allan Hackney, HITO (Co-Chair)	X	Ted Doolittle, OHA		Lisa Stump	
Joseph Quaranta (Co-Chair)		Stacy Beck	X	Patrick Charmel	X
Joe Stanford, DSS	X	Robert Rioux	X	Alan Kaye, MD	
Elizabeth Taylor, DMHAS		David Fusco	X	Dina Berlyn	X
Cindy Butterfield, DCF		Nicolangelo Scibelli	X	Tekisha Everette	x
Cheryl Cepelak, DOC		Patricia Checko	X		
Vanessa Hinton, DPH	X	Stephanie Burnham, OHS	X		
Dennis C. Mitchell, DDS	X	William Petit, MD	X		
Mark Raymond, CIO	X	Jeanette DeJesus	X		
Sandra Czunas, OSC	X	Robert Blundo, AHCT			
Supporting Leadership					
Victoria Veltri, OHS		Alan Fontes, UCONN AIMS		Carol Robinson, CedarBridge	X
Sean Fogarty, OHS	X	Tom Agresta, MD, UConn Health		Terry Bequette, CedarBridge	X
Adrian Texidor, OHS	X	Craig Jones, CedarBridge	X		
Tina Kumar, OHS	X	Sheetal Shah, CedarBridge	X		

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Agenda			
	Topic	**Responsible Party**	**Time**
1.	Welcome & Call to Order	Allan Hackney	1:00 PM
	Allan welcomed the group and called the meeting to order.		
2.	Public Comment	Attendees	1:05 PM
	SB Chatterjee indicated that he is working on submitting a public comment and will be ready for the next HIT Council meeting.		
3.	Review and Approval of Minutes January 16, 2020	Council Members	1:10 PM
	Allan Hackney asked for a motion to approve the Jan. 16 meeting minutes. Dr. Petit created a motion to approve the minutes. Mark Raymond and Vanessa Hinton seconded. Stephanie Burnham abstained. None opposed. The minutes were approved. Allan Hackney welcomed Stephanie Burnham as a new member of the HIT Advisory Council. Stephanie was appointed by Vicki Veltri to fill Mark Schaeffer's vacancy. Stephanie Burnham introduced herself and shared that she had previously presented the healthcare public score card to the Health IT Council. Stephanie's work at OHS focuses on practice transformation and payment reform for the State Innovation Model. Primarily, Stephanie manages the Quality Council and the Healthscore public scorecard. As it relates to HIT work, she has worked to evaluate eCQM'S and has been involved with other HIT initiatives.		
4.	Update on Health Information Alliance, Inc.	Allan Hackney	1:25 PM
	Allan Hackney provided an update on important developments with the Health Information Alliance, Inc. (HIA) Board and discussions with The Office of Health Strategy (OHS) and The Dept. of Social Services (DSS). Please refer to the update on page 6-16 here: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/Presentations/OHS_HITAC_Mtg_Presentation_022020.pdf#page=6. Allan reviewed the development that the Seed Money contract to allow injection of cash to the HIA has been finalized. This seed money contract provides three months of operating expenses in advance of the main contract that will be negotiated between OHS and HIA. This contract will cover topics including, contracted resources, occupancy, legal services, accounting, and insurance. The HIA Board has selected an insurance broker and developing insurance profiles to include cybersecurity and general liability. The HIA has signed a lease for		

space and has been accepted in the UConn Technology Innovation Program (TIP). The second area that is in process is that they signed a lease for office space; accepted into the health innovation program. The HIA has also begun basic banking operations and has retained the search firm Marcum, to search for an Executive Director.

Another important area of progress for the HIE is IAPD Reconciliation. The Council reviewed the proposed submission in 2018. CMS had combined FY2019 with FY 2020; two years of funding were combined in one fiscal year. Recasting of the financials is based on informing the contract with OHS & DSS in order for funds to be drawn from DSS. OHS has its own funding stream to administer health IT planning, including oversight of HIE. The difference is an acceleration funds to the HIE. These are the exact same line items the Council reviewed in 2018 that was approved by CMS. This is subject to final approval by DSS, who holds the ultimate fiduciary responsibility with HITECH funding. The concept that is important to follow is that OHS is incubating the HIA and that contracts with shift to the HIA as it stands up.

The Technical Assistance (TA) program went through Board Review and reflects their input. This program is designed to help Medicaid providers connect to the HIE by offsetting costs. Technical Assistance would also be provided in-kind by HIE itself. The TA Program is a milestone-based approach based after New Jersey's model. This model allows for ease of administration, and it provides an incentive for organizations to move across the continuum. Similar to Connecticut, New Jersey also utilized a payment approach where providers could receive an allotment based on their size/sophistication. The HIA Board has recommended a milestone percentage of 15/70/15 based on the short amount of time left in the HITECH Act. There were some other adjustments made to the TA Plan, as there was an overestimated the number of hospital connections, as well as mid-sized and small physician connections. The plan has increased HIE connections, as there is a known demand for New York and Puerto Rico to connect to Connecticut's HIE.

Allan Hackney reviewed the TA Program construction the 3 major milestones: legally connect, technically connect, data sharing. The plan will be to have organizations participate in two use cases. The focus is on Medicaid providers because that is a stipulation of the HITECH Act. The milestones were explained as follows:

- Milestone 1: Legally Connect – This means that organization executes two legal forms and qualifies for the first milestone payment.
- Milestone 2: Technically Connect – The use case exhibit allows data to be exchanged for a very specific purpose. The second area is to declare you HIPAA relationships; then that data would be eligible to exchange. If you do not have the same patients nor signed up for the same use cases, then you cannot exchange.
- Milestone 3: This is similar to Milestone 2; but the program requires a second use case where data is being shared.

Stephanie Burnham asked who's going to provide technical assistance and how will it be managed? Allan responded that the best to think of this is in two forms, the bulk (90%) is in form of cash disbursement and in

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	whatever way makes to cover connection costs. The other 10% is OHS resources that will be hired and used on as-needed basis to assist with technical connections. Allan reviewed the Proposed TA funding levels and outlined how the $17.6 allocated for technical assistance is the largest line item in the IAPD. This has been reviewed through the HIA Board and is subject to a final review with DSS. Allan reviewed developments on the SUPPORT Act including the announcement that funding was approved as it is a tri-agency collaboration with over $3.3 million in funds. Through Sept. 30 2020, the program is 100% federal funded. One of the focus areas will be to develop a connection between the Prescription Drug Monitoring Program (PDMP) and the HIA. Appriss Health is the vendor solution that Department of Consumer Protection uses for the PDMP and will be engaged to build out more connections to make the PDMP qualified to a federal standard as part of the SUPPORT Act. Another area of focus will be in PULSE, which will enable emergency workers and triage centers to have access to the PDMP if it were to go down during a natural disaster or time of emergency. This access would allow treaters to be able to provide care to displaced persons or those leaving a critical incident without their medical information or ability to communicate that data. The SUPPORT Act will be able to transition to a 90/10 funding stream after 9/30/2020. Pat Checko asked question related to last comment for any unspent funds converted to 90/10. Does this go back to DSS budget or does it mean that it can be reallocated? Allan Hackney answered that the SUPPORT Act will flow through DSS the same way HITECH funds move. Whether it's SUPPORT Act or MMIS, OHS petitions for funds and then is able to draw down. As it relates to unspent funds, the rules have not been published, but we have been instructed that 90/10 will be available to follow a MMIS style IAPD, but from a cash flow basis, other than the state having to find 10% match, there would be no difference. Pat Charmel asked for more information about PULSE. If PULSE was going to require infrastructure to be built, and how it would work. Allan responded that the architecture is typically HIE dependent. The app can exist on mobile devices and be portable. PULSE will connect to HIE and there's a feature to this which allows emergency responders to be designated on a real-time basis to perform certain clinical services such as prescribing. Pat Charmel followed up and stated that the PULSE HIE connection would be the central source instead of holder of record. Allan Hackney confirmed this is correct, and that there would be two points: managing real-time assignments of clinicians and then connections to one or more HIEs to access clinical data.		
5.	Update on All-Payer Claims Advisory Group	Allan Hackney, Patricia Checko, Adrian Texidor	1:50 PM
	Adrian Texidor indicated that CT's APCD is a national model which includes all three data types: commercial, Medicaid and Medicare. He anticipates that they will receive Medicare data by the end of February.		

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The updated **Submitter Status Report** can be referred to here: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/Presentations/OHS_HITAC_Mtg_Presentation_022020.pdf#page=19. This captures all the payers and the subset of payer plans that submit data to CT's APCD. As a note, eviCore is highlighted as they are working to resolve technical difficulties.

CMS and Medicaid Data Use Agreements Regarding Medicaid, they will use a master Memorandum Of Agreement (MOA) that will govern work between OHS/DSS. There is one caveat, for each and every single use of Medicaid data, they have to ask Medicaid since there is a specific federal regulation that Medicaid has to review the request for research. As it relates to Medicare, CMS approved an amendment which allows OHS broad authority to use Medicare data for in-flight projects: cost-growth benchmark, quality benchmark, and cost estimator. Currently working with CMS and RESDAC to get extended data use.

RAND Hospital Price Transparency 3.0 OHS will participate in this study. It began as a price transparency study for hospital services. They want employers to be better informed shoppers; hold hospitals/hospital systems accountable and report hospital prices relative to Medicare benchmark. RAND Corporation will utilize CT's APCD data sets to prepare a specific price report. The goal is to use the study to understand the patterns in pricing data and specify analytic methods for the future and provide key takeaways for administrators.

Pat Charmel asked when the 3.0 will be published. The 2.0 version was from midwestern states, is it going to be all states they have data for? Adrian answered that it will be published sometime in Spring 2020 the report will be issued, heard May. And also, yes, 2.0 covered eFI and Anthem Midwest division. This report includes entire universe of submitters. Adrian is not aware of the what the universe of submitters are but will follow up with a response. Pat Charmel asked if there will be a preview before it is published, Adrian hopes so and that he is excited that RAND chose CT as one of the submitters. Pat acknowledged that he does not believe the provider community will be as excited about it.

Healthcare Affordability Standard Adrian reminded the Council about the self-sufficiency standard that State premiered back in 2014. Phase one was to define the real costs to consumers. There were 3 objectives in Phase 1: define a baseline, conduct a targeted review and develop calculation of total cost of healthcare. They collaborated with University of Washington and UConn AIMS. Phase 2 of the project will be to build and test CT Healthcare Affordability Standard. Expect tool to be ready by Spring 2020; on track to meet that timeline.

Healthcare Cost Estimator includes updated data; please send email to Adrian or Allan if you would like to be part of this. They will continue to iterate and add design features to the cost estimator until we have satisfied requirements of the CT General Statute.

ACPD Data Release Activities Pat Checko, Chair of the APCD Data Release CM shared that the DRC is responsible for reviewing applications. They started working on this with Rob Blundo. Since that time have actually reviewed and approved 15 different applications from external sources. And those 15 applications included 18 different initiatives. Adrian is dealing with OHS projects that have very different MOAs and access to

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	more data than they are allowed to release under the law through the DRC. Pat indicated they can only provide de-identified data with 18 identifiers removed and masked dates of services. As a researcher, you can see how that would limit your ability to do certain kinds of significant research. The DRC is planning to send out a survey to better understand process. The survey will look the process, data issues, and if they were able to answer the research questions they were asking. In the final analysis, we know application itself is useful. In the current application, we ask for 200 words or less so the first thing they want to take on is create a workgroup to develop an application that is easier for the applicant to use and those reviewing it. Under current rules, data is de-identified and if you are trying to look at readmissions or know how many people are receiving PreP for HIV, we can't even give you a zip code. As they record issues/concerns, statute really limits the use of the APCD data. They will talk about different groups that have access to data. Dave Fusco asked how many people are using the data? In a commercial space, as you think about individual/small groups, at different points of time folks were opting out. Allan Hackney responded that we do not get self-insured claims with exception of state run. If you look at self-insured claims, they get about 50% of them. Because of ERISA, no obligation to submit plans. Dave asked if there is any type of disclosure? Do we need to represent that we do not have all the data? Adrian responded that if you have PReP NDC code; or can look at JCode; then you would know who have receive PReP and not able to go to level of granularity that many researchers would like to go. OHS has limitation. Allan clarified that Dave's question is about do people know the limitations of data? Pat Checko responded Yes, absolutely correct – even re-writing directions, should have background information that states what they should have and what they don't have so people can realize data is reflective of a limited sample. Allan Hackney announced that there will be some reorganizing of staffing resources in OHS. Olga Armah will oversee the APCD day to day management going forward. Currently, she runs the data analytics team at OHS, and Allan is confident she will serve the needs of the APCD successfully. This enables Allan to concentrate more on emergence of HIE and other Health IT activities.		
6.	Announcements and General Discussion	Allan Hackney	2:30 PM
7.	Dina Berlyn wanted to express her concern and the concept of insurers trolling your data without specific consent is a problem. Dina shared that she was not comfortable with view in article about health insurances access to data in HIE. Patient was primary and providers were secondary and that wasn't intended use of legislation. Allan responded that the article wasn't quite as clear. He clarified that in order to access data in the HIE, you have to have a HIPAA business relationship for TPO and you have to have a use case agreement with another organization wants to share data. The carriers are interested in clinical care summary documents. This allows them to more efficiently manage the benefit plans, they have information today but are doing it through laborious chart reviews. That is what the payer interface is. Across the nation, most HIEs are taking HITECH funds and under HITECH Act you have to share data with Medicaid. That's the way they have always viewed		

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	payer access, they would sign the same trusted agreement and would sign all the agreements like everyone else. Dina shared that the article said that they would access to individual information. Allan said that this would give him concern too because that's in violation of the use case. Dina also feels like that we lose the patient in the conversations. Allan agreed, once we get to scale, view of OHS, Council and everyone else is that we have to make it available to all patients. If we go back to the use case design group, patient access is important but unless you have scale it's a hit or miss for any patient. Dr. Petit inquired about responses to recent articles published that contain some misleading or factually incorrect information. Allan responded that OHS was monitoring the media channels and had differing strategies according to the outlet. Allan added that he would like to present a charter for the Health IT Advisory Council including how members get selected and ground rules. They have been found that to be quite useful for 3 different groups and we will develop a charter based on 3 precedented templates with our intention is to have a general discussion for first read for March meeting. It's been useful in the other groups and for vacancies that come up from time to time. Dr. Quaranta and Allan have wrestled with vacancies for quite some time and one seat that has never been filled since Council was created. Mark Raymond suggested that we should simply state our consent policy - both for HIT and HIA in a place that can be available to the public. While it's a complex topic, we need to find a simple way to communicate our desire to empower the consumer to protect their own privacy. Allan answered that the guiding principles for public comment are posted on the OHS website for the last five days, OHS has broadcasted this to all the listservs that OHS maintains for different groups and public so we call attention for feedback.		
8.	Wrap up and Meeting Adjournment	Allan Hackney	3:00 PM
	Allan Hackney asked for a motion to adjourn. Vanessa Hinton created a motion. Tekisha Everette seconded the motion. The meeting adjourned at 3:00 pm.		

Upcoming Meeting Schedule: March 19, 2020

Meeting information is located at: https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council