Health IT Advisory Council

November 15, 2018

Agenda

Agenda Item	Time
Welcome and Call to Order	1:00 pm
Public Comment	1:05pm
Review and Approval of Minutes – October 18, 2018	1:10pm
Updates • APCD • IAPD/ SMHP	1:15 pm
State Innovation Model (SIM) Updates • Primary Care Modernization • Health Enhancement Communities	1:45 pm
Wrap-up and Meeting Adjournment	2:45pm

Welcome and Call to Order

Public Comment

(2 minutes per commenter)

Review and Approval of:

October 18, 2018 Meeting Minutes

Updates on:

- APCD
- IAPD and SMHP

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All Payer Claims Database (APCD) Update

Action Items - Funding

FY20+ Funding

- ❑ ***OHS agency funding unlikely to be sufficient:***
  - All agencies explicitly instructed not to seek funding increases in upcoming session
  - OHS has never had APCD funding in its budget lines

- ❑ ***Investigating HITECH Act Federal funding:***
  - Possible 90/10 match funding for repositioning APCD technology to lower run-rate environment
  - Possible 75/25 match funding for on-going operations
    - Must meet seven conditions…may be a challenge

- ❑ ***Investigating SIM funding:***
  - Integration with Core Data and Analytic Solution (CDAS) supporting SIM eCQM project may reduce run-rate

Advisory Group recommended pursuing all avenues for funding;
however, a primary emphasis should be on HITECH Act funding consistent with other states

APCD Policies and Regulations

OHS-specific APCD Policies

- ***As a quasi-public entity, AHCT can enact policies by review and adoption by the AHCT Board of Directors:***
  - AHCT board adopted two policies governing the APCD:
    - General policies and procedures (approved Dec. 5, 2013)
    - Privacy policies, incl. data release (approved Feb. 18, 2016)
  - AHCT operates under these policies on behalf of OHS via MoA

- ***With respect to general APCD policies, OHS will adapt the current policies to its mission and situation:***
  - It is typical that agencies adopt agency-specific policies governing intent and expectations for work within the scope of mission

- ***With respect to data release APCD policies, OHS must publish regulations:***
  - Per Office of the Attorney General, OHS must pursue regulations regarding it's process and rules for submitting and releasing data

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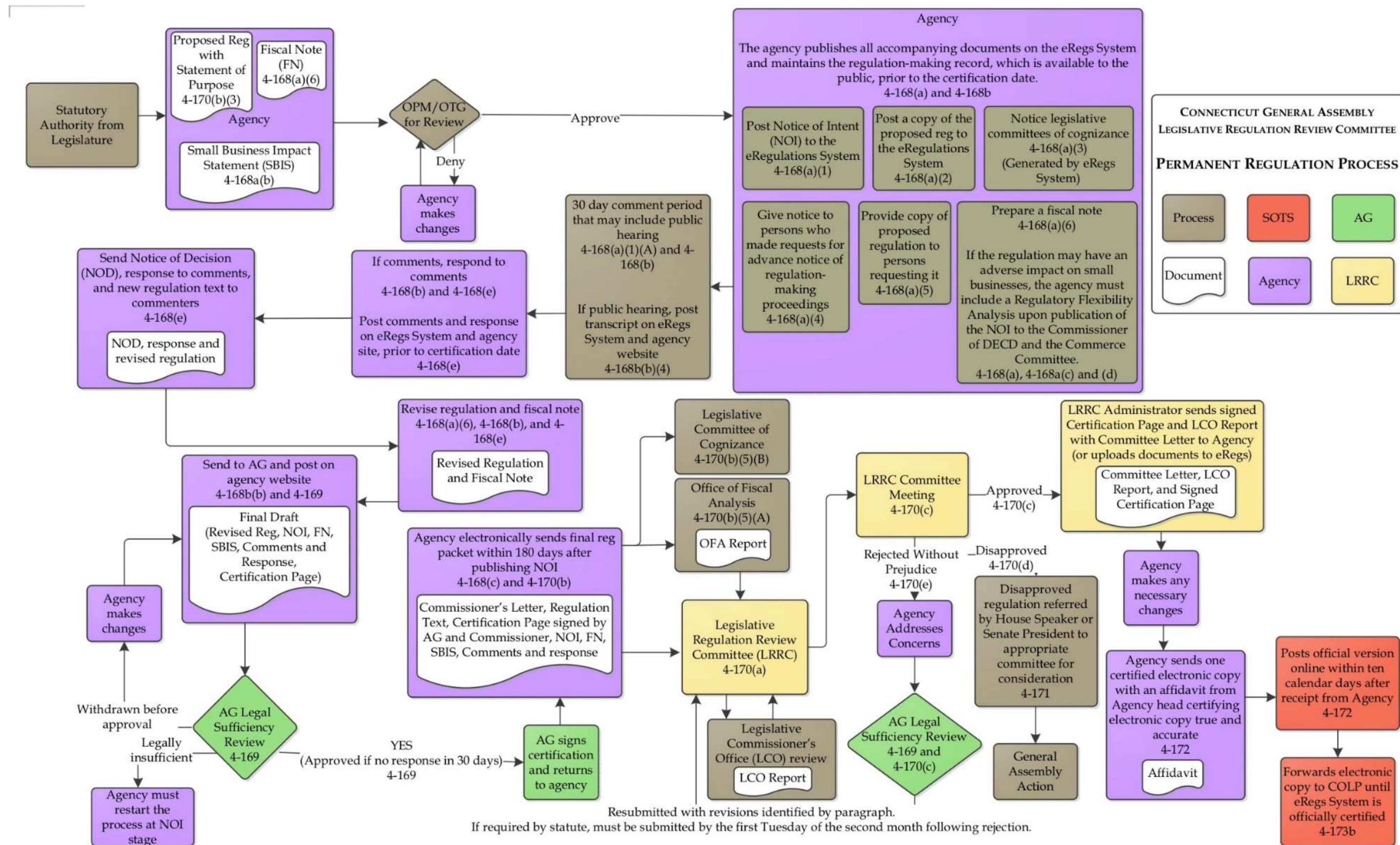
CT Regulatory Process



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APCD Regulatory Design Group

APCD Regulatory Design Group

- ***Proposing establishing a Design Group to advise on regulatory content:***
  - Review and comment on:
    - Existing AHCT policies
    - APCD policy practices from other states
    - Current or anticipated concerns from data recipients, OHS staff, etc.
  - Develop an outline of a proposed regulation
  - Present recommendations to the APCD Advisory Group for review and affirmation (Feb 2019)

- ***Design Group process:***
  - Proposing three to four 90-minute sessions across three months, starting late Nov 2018
  - Process to be facilitated similarly to HIT Advisory Council Design Groups

- ***Seeking four to six APCD Advisory Group members to participate:***
  - Alternatively, an advisory can designate a committed subject matter expert

Advisory Group agreed with the recommendation and,
further recommended re-energizing the Privacy Subcommittee for this purpose

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Action Items – Interim OHS Data Access

Interim OHS Use of APCD Data

- ***Administrative "paper trail" will necessarily take many months to simplify:***
  - OHS use of data will be severely curtailed during this period

- ***Pursuing separate "enclave" for OHS:***
  - OHS to contract separately with OnPoint for separate OHS-only work area
  - OHS and AHCT amend the MoA:
    - Permit loading a copy of the Pseudo-LDS when periodically delivered the to AHCT work area
    - OHS to indemnify AHCT for use of data in the OHS-only work area

Advisory Group agreed with this approach to the extent practical. Subsequently, AHCT may pursue a complete transfer of functions to OHS

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Action Items – Specialized Data Releases

Specialized Data Releases and Analysis

- ***OHS and AHCT lack bandwidth to support filtered data releases and analysis:***
  - A program for basic data release works well; however…
  - Requesters are increasingly asking for Safe Harbor releases aggregated using specific filters (e.g., XYZ zip codes, XYZ procedure codes, etc.)
    - Each filtering request requires analysis of data, programming and testing

- ***OHS proposes establishing a position with analytic skills to address bandwidth issue:***
  - Proposal is to replace an existing and vacant IT Analyst position with a Data Analyst
    - Role would combine data analysis needs for both the APCD and the Health Systems Planning unit that oversees the Certificate of Need (CoN) process
    - Role would have access to identifiable data (i.e., claims and hospital discharges)
    - Security access controls would be normalized across these data domains

Advisory Group agreed with this approach to the extent practical;
Noted that the State is under-resourcing the APCD

IAPD-U and
State Medicaid HIT Plan (SMHP)

IAPD-U and SMHP

Preparing for a new IAPD-U

- ***DSS intends to submit an IAPD for FFY19-20:***
  - Targets initial request for FFY20 Federal 90/10 funding
  - DSS is required to submit an update to the SMHP as a condition for any further funding

- ***OHS proposes submitting additional requests together with the DSS submission:***
  - Primary request is technical assistance for organizations to connect to the HIE
    - Will propose a model similar to NJ that provide incentives for progress organized by hospitals, physician groups and other health care organizations
  - Also considering requesting funds for a "Use Case Factory":
    - Concept borrowed from MI
    - Gives flexibility to consider potential use cases that have emerged since the HIE Design Group recommendations
      - Precision medicine, acceleration of medication reconciliation, possible PDMP connection

- ***Consistent with statute, the IAPD request will be brought to the Council during Dec. 2019***

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State Innovation Model (SIM) Updates

Primary Care Modernization and Health Enhancement Communities: Pathways to Better Care and Better Health

How We Will Spend Our Time Together

- Discuss CT healthcare reform history and current landscape
- Discuss two design initiatives to promote better care and better health: ***Primary Care Modernization*** and ***Health Enhancement Communities***
- Share information on a Medicare Multi-payer Demonstration as the vehicle for advancing these reform initiatives
- Consider relationship to the work of the HIT Advisory Council

We are seeking *your advice and expertise* as we move forward with this important work

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Healthcare Reform in Connecticut

- Widespread adoption of the ACO or “shared savings program model”
- More than 85% of Connecticut’s primary care community in ACO arrangement
- SIM achievements
  - 180,000+ Medicaid beneficiaries in PCMH+ shared savings program
  - 1,000,000+ beneficiaries (all payer) attributed under shared savings arrangements
  - Commercial payers 60% aligned on Core Quality Measure Set
  - 125 practices achieved PCMH recognition through SIM
  - 5 provider organizations representing 735 PCPs and 414,174 attributed lives receiving Community and Clinical Integration Program support
  - 14 provider organizations and CBOs negotiating service agreements under Prevention Service Initiative
  - Implementation of information exchange and data analytic solutions underway

Healthcare Reform in Connecticut

- Limitations…
  - Primary care remains largely untransformed
  - Limited investments in preventing avoidable illness and injury

The Opportunity

- A multi-payer demonstration project to improve health, drive efficiency and reduce total cost of care (with Medicare participating, but not a "state-run" Medicare program)
- Pay for primary care differently by leveraging payment 'bundles' to support advanced care delivery
- Focus on payment features that facilitate using some resources at the system level and the practice level
- Create an innovative community-driven model that can encourage investments in community health by monetizing prevention efforts

Primary Care Modernization

Primary Care Payment Reform

Unlocking the Potential of Primary Care

February 1, 2018

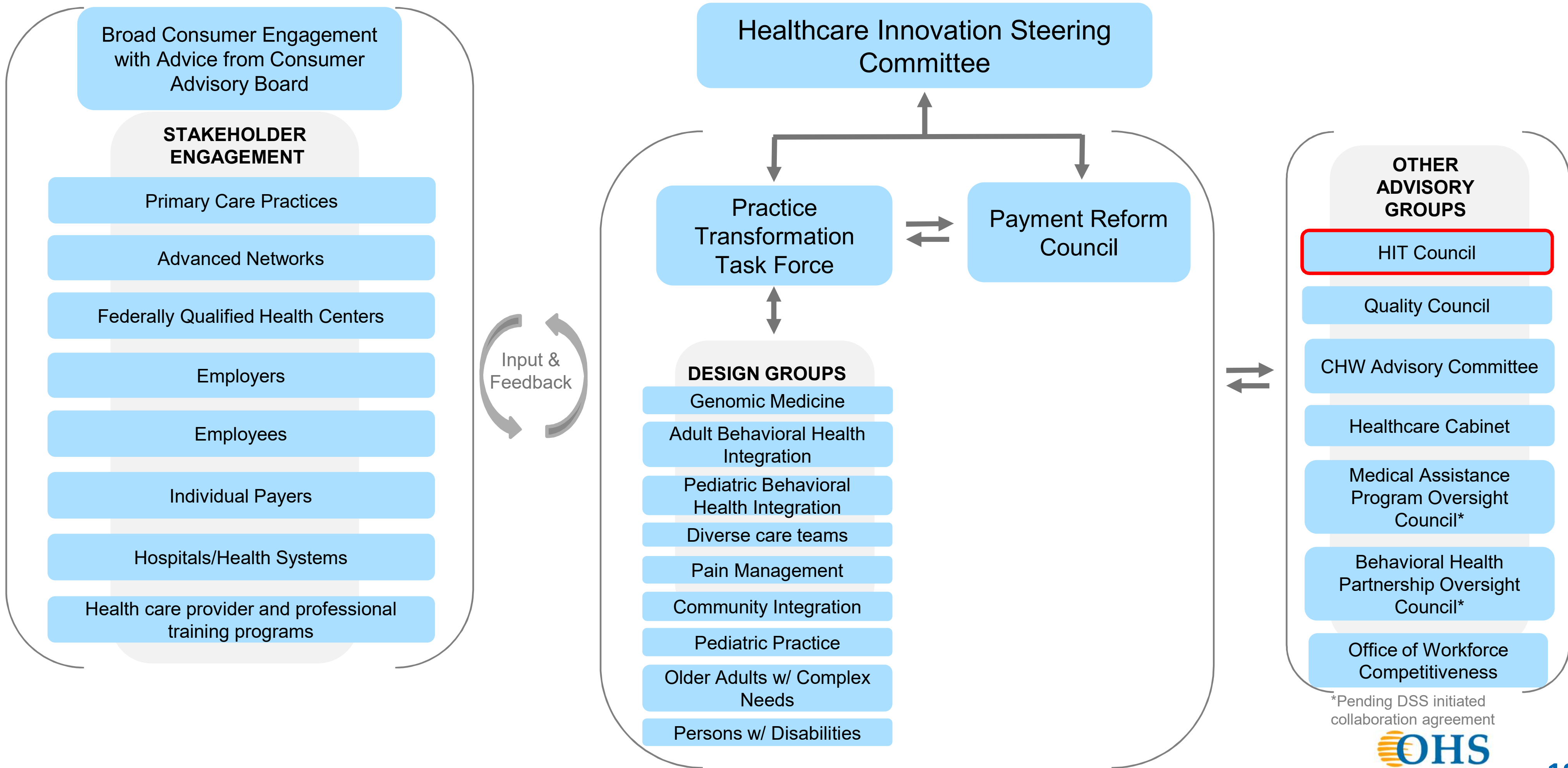
Design a new model for primary care to:

- Expand and diversify care teams
- Expand patient care and support outside of the traditional office visit
- Double investment in primary care over five years through more flexible payments
- Reduce trend in total cost of care

Foundational Assumptions for designing model:

- Eligibility limited to practices in Advanced Networks/ACOs/FQHCs
- Multi-payer
- Existing MSSP or other shared savings arrangements remain in place, but model introduces downside risk *(may propose program adjustments)*
- Hybrid, partial or full bundles for primary care services

Stakeholder Engagement Progress



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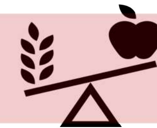
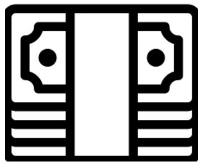
Capabilities Under Consideration

Diverse Care Teams	Pharmacists, Nurses	Care Coordinators, Community Health Workers, Navigators	 Health Coaches, Nutritionists
Alternative Modes of Support & Engagement	Phone/Text/e-mail	Home Visits	Telemedicine
Technology	Patient generated data & Remote patient monitoring	Precision & Genomic Medicine	E-Consults
Integration and Specialization	Behavioral Health Integration	Practice Specialization (e.g., geriatrics, chronic pain)	Community Integration

Payment Reform Model Options Under Consideration

Basic Bundle **Supplemental Bundle** **Fee for Service Payments**



MSSP or Other Shared Savings or Downside Model Risk Puts Pressure on Total Cost of Care

Options:
Hybrid basic bundle (partial bundle with reduced fees for office visits)
Combined bundle (single upfront payment that combines basic and supplemental bundles)

Primary Care Modernization

High level timetable

2017 – June 2018

- Practice Transformation Task Force recommendations for primary care transformation
  - PTTF undertakes stakeholder engagement and preparation of report and recommendations; public comment
  - Healthcare Innovation Steering Committee approval of report and recommendations

July – Dec. 2018

- Model Design Phase
  - PTTF: proposes core and elective capabilities with design groups and intensive stakeholder engagement
  - PRC: Specific payment model options for Medicare and recommendations for other payers
  - Provisional recommendations to new Governor's transition team

2019

- Payment Model Development (contingent on support of new Governor)
  - Draft concept paper to CMS incorporating specific payment model options for Medicare
  - Negotiate Medicare agreement with CMS
  - Other payers develop their payment models in alignment with Payment Reform Council recommendations
  - Payers begin pre-implementation activities to operationalize new payment model

2020

- Implementation
  - Jan. – June: Payers continue pre-implementation activities
  - July – Dec.: Best case target date for Primary Care Modernization "go-live"

Looking Ahead: Role of HIT in PCM

Opportunities for leveraging OHS HIT may include:

- **Improving care delivery through HIE's Two Way Information Exchange Resources Across Settings and Networks. Examples may include:**
  - Expanded Use of Diverse Care Teams
  - Home Visits
  - Telemedicine
  - E-Consults
  - Remote Patient Monitoring
  - Behavioral Health Integration
  - Community Integration
- **Informing Program Oversight through CDAS's Advanced Analytics and Reporting to Monitor Performance. Examples may include:**
  - Ongoing service utilization monitoring on expected vs. actual service levels
  - eCQMs/Quality Council common measure sets

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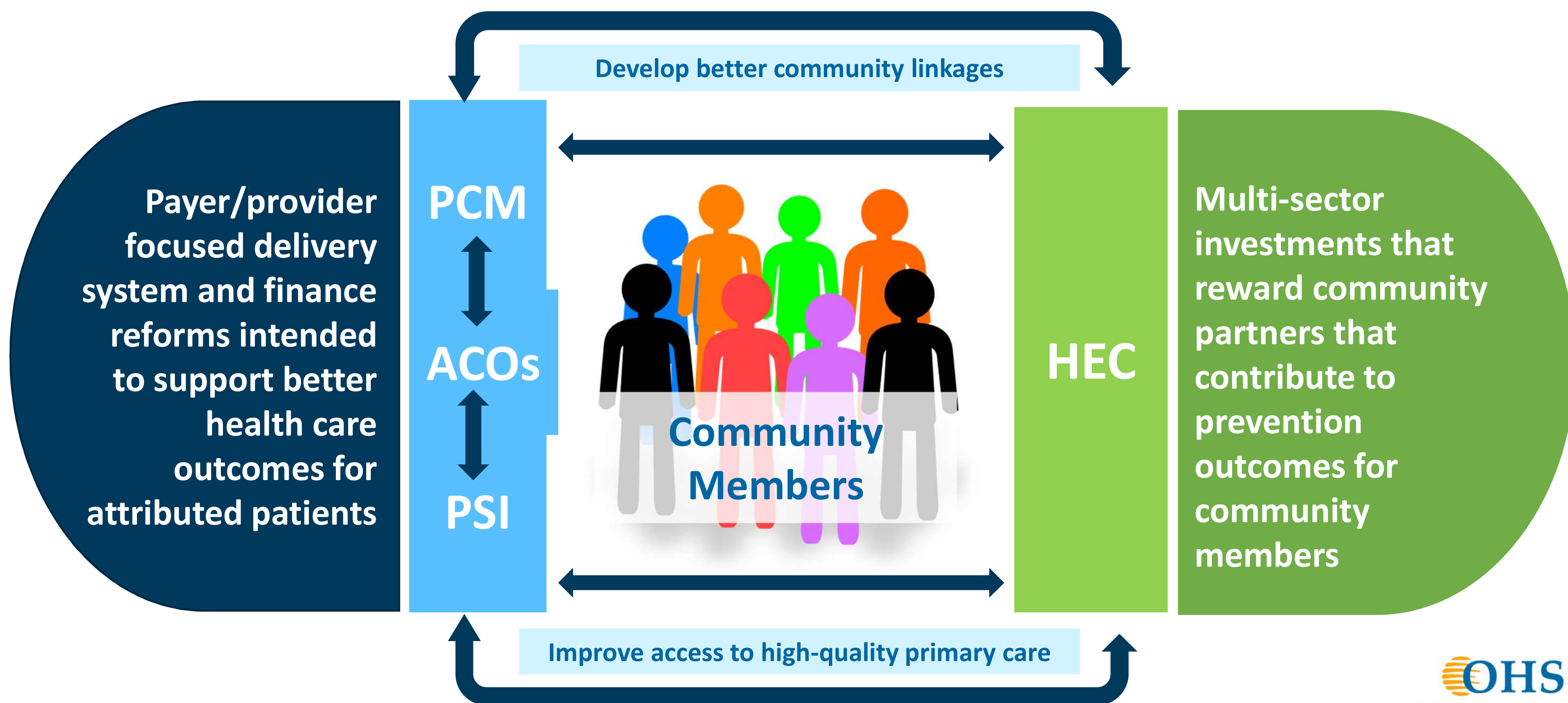
Aligned and Complementary Reforms

Connecticut's augmented strategy to incentivize quality and prevention



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Health Enhancement Community Initiative

Proposed Features

- HECs will be new, multi-sector collaboratives operating in defined geographic areas that will be accountable for:
  - Improving child well-being for Connecticut children aged 0-5 years
  - Improving healthy weight and physical fitness for all Connecticut residents
  - Increasing health equity
- HECs will implement multiple, interrelated, and cross-sector strategies that address the root causes of poor health, health inequity, and preventable costs.
- HECs will operate in an economic environment that is sustainable and rewards communities for prevention, health improvement, and the economic value they produce.

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Primary Priorities Across HECs

Improve Child Well-Being

Prevent and Mitigate Adverse Childhood Events

Increase Healthy Weight and Physical Fitness

Prevent Overweight and Obesity

Improve Health Equity

HECs may also select additional priorities but the intent is to have a statewide focus and move the needle at a statewide level.

CURRENTLY PROPOSED

HIT Implications of the HEC

- The Health Enhancement Communities will need to be able to conduct analytics activities that track the health and wellness of their populations across multiple HEC interventions.
- A robust IT and data infrastructure is critical for HECs to achieve their goals and collect and report on provisional statewide measures.

CURRENTLY PROPOSED

HIT Implications of the HEC

- The HECs will need to utilize an IT and data infrastructure that will both extract and receive feeds of data from various sources, including clinical sources to which partners within HEC may not have previously had access.
- To accelerate the process of developing an infrastructure that will best support the HECs, the HEC Initiative can leverage the Core Data Analytics Solution (CDAS) currently in development by OHS, with analytics resources at the University of Connecticut (UConn) Analytics and Information Management Solutions (AIMS) group.

What is CDAS?

CURRENTLY PROPOSED

- The University of Connecticut (UConn) Analytics and Information Management Solutions (AIMS) group is focused on:
  - The design and development of advanced innovative person-centered analytics and information management solutions to support initiatives that promote healthier people, smarter spending, and health equity.
- **Core Data Analytics Solution (CDAS) Goal:** Create an innovative, open architecture solution that will open the lines of communications across the State between people, communities, consumers, providers, payers, and employee groups (all-inclusively labeled "stakeholders").

How Will CDAS Support HECs?

CURRENTLY PROPOSED

- CDAS will acquire and create a sizable foundation of the state's health data, such as the All-Payers Claims Database (APCD), clinical data, medical and pharmacy claims data, and social determinants of health.
- The data within the CDAS will be used to create advanced innovative analytics to provide information and insight to guide and support interventions.

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How Will CDAS Support HECs?

CURRENTLY PROPOSED

- It will provide information to stakeholders, like HECs, so that they can proactively monitor and manage programs and interventions to ensure impactful outcomes.
- Advanced analytics will be important to quantify the potential return on investment in populations in support of value-based, multi-payer strategies.

CURRENTLY PROPOSED

How will CDAS support HECs?

- Create cost-efficiencies for implementation across the HEC such that they reduce the analytics burden on the HEC.
- Ensure flexibility to include data elements such as social determinants of health, family history, medical and surgical history.
- Accept data formats from most sources (i.e. excel, access dbase) to accommodate most HEC providers (including those who don't currently have robust HIT in their settings).
- Allow for the segmentation of all of its reports, metrics, and analytic tools by any number of markers or factors.

CURRENTLY PROPOSED

CDAS HEC Example

- HECs could utilize CDAS to do the following:
  - Access baseline data to identify hot spots of need within the local HEC geography to better target interventions
  - Upload HEC intervention outputs to meet reporting requirements and track activities
  - Monitor local HEC progress toward statewide prevention benchmarks

Wrap up and Next Steps

Next Health IT Advisory Council Meeting:

Thursday, December 20, 2018 | 1:00pm – 3:00pm
Legislative Office Building, Hearing Room 1D

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https://portal.ct.gov/OHS/HIT-Work-Groups/Health-IT-Advisory-Council

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