District of Columbia
Health Information Exchange
Policy Board Meeting

Thursday, June 23, 2016
2:00 – 4:00 PM

Location:
One Judiciary Square
441 4th Street, NW
Main St. Conference Room, 10th Floor
Washington, DC 20001

Board Members:	**Members present (11):** ***Chris Botts*** (DC Department of Health Care Finance); ***Edwin Chapman, MD*** (Private Practice and Leadership Council for Healthy Communities); ***Kelly Cronin*** (The Office of National Coordinator); ***Angela Diop, ND*** (Unity Health Care, Inc.); ***Victor Freeman, MD*** (JA Thomas & Associates); ***LaQuandra Nesbitt, MD*** (DC Department of Health); ***Donna Ramos-Johnson*** (District of Columbia Primary Care Association); ***Alison Rein*** (AcademyHealth); ***Claudia Schlosberg*** (DC Department of Health Care Finance); ***Eliot Sorel, MD*** (Medical Society of the District of Columbia); ***William Ward*** (Catholic Charities) **Members present via teleconference (6):** ***Zach Hettinger, MD*** (MedStar); ***Mary Jones-Bryant, RN*** (District of Columbia Nurses Association); ***Justin J. Palmer*** (DC Hospital Association); ***Pete Stoessel*** (AmeriHealth); ***Sakina Thompson*** (DC Department of Human Services); ***James Turner*** (Health IT Now Coalition) **Members absent (5):** ***Christian Barrera*** (Office of the Deputy Mayor for Health and Human Services); ***Brian Jacobs, MD*** (Children's National Medical Center); ***Tonya Royster, MD*** (DC Department of Behavioral Health); ***Brian Sivak*** (Robert Wood Johnson Foundation and Civic Hall); ***Archana Vemulapalli*** (DC Office of the Chief Technology Officer); **DHCF/HCRIA/HIE Staff present (2): Dena Hasan,** Jordan Cooper, Michael Tietjen **Guests (5):** Scott Afzal (CRISP); Andersen Andrews (DCH); Chioma Aneke **(**on behalf of ***Christian Barrera*** (Office of the Deputy Mayor for Health and Human Services)); Nancy Black (on behalf of ***Tonya Royster, MD*** (DC Department of Behavioral Health)); James Costello (DCPCA); Tina Curtis (OAG-OHPC); Selwyn Eng (Mary's Center); Luigi Leblanc (Zane Networks); Kory Mertz (CRISP); LaRah Payne (DHCF); Anita Samarth (Clinovations GovHealth); Allison Viola (Kaiser Permanente);
Documents for Review:	1) Board Meeting Slide Deck, 2) Sustainability Subcommittee Board Chair Report, 3) Sustainability Subcommittee Charter, 4) HIT Enabler Section of Draft DC SHIP
AGENDA	

1. Call to Order **2. Announcement of Quorum**	Mr. Botts called the meeting to order at 2:07pm. He called roll and announced that there is a quorum.
3. Approval of the Minutes of the Previous Meeting	Mr. Botts announced that there are no new minutes to approve. He explained that the minutes for April 21st do not need formal approval from the Board since it was closed to the public and, therefore, will not be posted on the public website.
4. IAPD-U for FY16-17 Update	Mr. Botts updated the Board, notifying them that DHCF formally submitted its HITECH IAPD-U to CMS on June 1, 2016. As a reminder, this IAPD-U covers five HIE-related initiatives: 1) Dynamic patient care profile, 2) eCQM dashboard, 3) Obstetrics/prenatal specialized registry, 4) Analytical population health dashboard, and 5) TA support to improve HIE ambulatory connectivity in the District. DHCF expects to receive CMS approval by early-mid July 2016. Mr. Botts further explained that DHCF will look to release competitive grants by the end of this fiscal year to implement these initiatives beginning in early FY2017. Dr. Freeman asked for further elaboration about the HIE connectivity effort and Mr. Botts responded that DHCF is planning on engaging ambulatory providers about the importance of connecting to an HIE and on providing technical assistance aimed at incorporating their advanced services into their practice workflows. Ms. Rein asked about the eCQM dashboard and whether it is specific to CRISP. Mr. Botts responded that every initiative must be competitively bid. Therefore, no specific initiative is tied to any one HIE entity, including CRISP. He added that in the future, DHCF will be able to leverage the HIE Designation process to streamline the implementation of IAPD-related initiatives. Ms. Cronin asked about the clarified interpretation of the 90/10 federal match that was established in the State Medicaid Director's (SMD) letter dated on February 29, 2016. Mr. Botts responded that DHCF has been researching ways to best leverage this new guidance, which has included an initial environmental scan of the current HIT infrastructure of long-term, post-acute care facilities and pharmacies. It may be possible to submit an additional update to the FY16-17 IAPD-U for FY2017 to accommodate these new funding opportunities. However, based on the current availability of local funds, it is more likely that DHCF will have to target the FY18-19 IAPD for such efforts. Ms. Rein asked if there are any opportunities to build in the SMD updates to our current IAPD-U initiatives and Mr. Botts responded that it would be dependent upon the level of effort, and available local funds, required to implement such initiatives. If it's a light lift, DHCF always has the ability to submit another IAPD-U for these additional stakeholder types. Ms. Schlosberg asked about interconnectivity between Health Homes 1, iCAMS, and other APM programs. Mr. Botts said that we are trying to incorporate all of our efforts in a seamless fashion, which we have tried to reflect in our most recent draft of the District's State Health Innovation Plan (SHIP) associated with the District's SIM grant with CMS.
5. HIE Designation Update	Mr. Botts reviewed DHCF's plans to establish a formal HIE Designation process. The Designation Process would set a minimum set of standards and functions that HIEs would need to meet in order to become designated entities. Through designation, these entities would be eligible to receive more direct funding, such as grants, from the District. DHCF is expecting to promulgate new legislation and regulations authorizing the HIE Designation process by Spring or Summer of 2017.

	Dr. Freeman asked about differences between Health Information Organizations (HIOs) and Health Information Exchanges (HIE). He asked if the Board is defining HIOs as one corporate entity (potentially with many delivery sites, e.g. Unity Health) and HIEs as an entity that functions as one hub for many other entities (e.g. DCPCA's EHX Hub). Mr. Botts affirmed Dr. Freeman's initial impressions that HIOs will most likely be defined as one corporate entity and that HIEs function as a hub for other entities. However, he noted that these specific definitions have yet to be finalized.
6. District Mapping Project Update	As introduced in March's Board meeting, DHCF has undertaken a data mapping project with the goal of establishing a stronger foundational understanding of the healthcare connectivity in the District. This includes highlighting the various data flows, data stores, and data access mechanisms in the District in order to help identify potential gaps and barriers that need to be addressed in the future. Navigant Consulting, DHCF's SIM contractor, and Navigant's sub-contractor, Clinovations GovHealth, have helped DHCF map the District's HIT infrastructure with iterative, draft documents. Mr. Botts stated that one of the major challenges highlighted from this work is that the exchange and access to key clinical information tends to differ depending on where a patient enters the healthcare system point (e.g., information about a patients care may be more accessible if they enter via a hospital's ER department than if they are seen by primary care physician located in an independent practice). One of DHCF's primary objectives of the District's HIE ecosystem is to make sure all key health-related data can be transmitted and accessed at the right place, at the right time, and in the right format by any patient or provider that needs it to manage or improve care. Ms. Rein asked what constitutes an independent clinic, specifically asking if retail, pharmacy clinics such as a CVS Minute Clinic would be considered independent. Mr. Botts said that an independent clinic is one that is not associated with a large, integrated health system and added that the initial phase of the project did not investigate those types of pharmacy clinics specifically. He acknowledged that the initial phase of this effort was not able to capture every end user type or organization but begins to generally represent the current state of health-related data exchange in the District. Dr. Sorel asked if DHCF has paid particular attention to data security, which cuts across all subject areas. Mr. Botts replied that this phase of this work did not dig into the technical aspects of data security, but will plan on doing so in subsequent phases of this work. Dr. Sorel said data security needs to become a higher priority for the Board because an absence of adequate security could undermine trust in the HIE system. Mr. Botts agreed that security, in addition to privacy, is important topics that should be addressed. He added that DHCF is looking to address both these topics as part of the HIE Designation process. Dr. Sorel continued, asking if there is a way to capture utilization of medications across systems, which he suggested would be helpful for assessing health outcomes. An HIE that had access to medication utilization data would facilitate care coordination, improving quality and reducing costs. Ms. Hasan applauded the work of the team, specifically Clinovations and DHCF/HCRIA staff, for documenting the current state of data in the District including what the data is, where it is stored, and where it flows. Mr. Botts stated that this Data Map can now be used as a centralized repository that can serve as a starting point for future conversations. Segueing from the topic of a centralized data repository to DHCF's Medicaid Data Warehouse (MDW), which is being built as a repository for Medicaid claims data, Ms. Schlosberg asked the

	Board about its vision for how to use the MDW in the future and whether it could be expanded to an all-payer claims database (APCD). Ms. Schlosberg suggested that though the MDW is being created to hold a more robust set of Medicaid claims data, one possible use of the system could be to bring in data from other systems to create a larger set of health data that spans across payers. Mr. Botts said it was his understanding that the MDW will aggregate data from several different systems (DCAS, case management systems, DHCF web portal), in addition to responding to new use cases, such as the prenatal registry, in later phases. Ms. Schlosberg asked if the MDW will be able to incorporate data from other payers, including Medicare data that DHCF has access to. Mr. Botts said that the MDW has that potential, but was not aware of any explicit plans currently in place to do so. Mr. Stoessel asked if the MDW would also include denied claims and Ms. Schlosberg replied that she believed that was the case since she could view claims data that has been paid, submitted, and denied. She encouraged Board members to view the MDW as a tool that can be used in some other ways in addition to its primary use case. Dr. Freeman asked if there is a community body with oversight of the MDW. Ms. Schlosberg replied that the HIE Policy Board offers some oversight though the MDW has been internally driven and built initially for DHCF-specific purposes. Mr. Ward said that a MDW is a great place to start a discussion on utilization, services that are being received, where the services are being received precisely because DHCF has been successfully collecting claims data for a long time. The MDW is standardized claims data that has value now that can be added upon in the future. Mr. Botts said that a centralized data repository such as the MDW would present many benefits including providing the opportunity to aggregate many pieces of information about one person in one place. However, he stated that the Board ought to remain vigilant about privacy and security issues since a security breach would place more data at risk than would otherwise have been placed at risk before the data was aggregated. The first phase of the MDW will be online at the end of this FY 2016. Ms. Schlosberg invited the Board to join a call with Michigan about their CDW expansion and rollout. Mr. Botts extended a special "thank you" to Anita Samarth and Kristie Scott from Clinovations for their work on the District Data Map initiative. Ms. Rein asked for a call with the Clinovations team to discuss the District's Data Map. Mr. Botts suggested that it may be necessary to establish another committee to have this conversation instead of allocating the topic to the Sustainability Committee since there is already so much on their plate. *Action Items:* - *2-3 Board members shall volunteer to join Dr. Schlosberg's call with Michigan about their CDW expansion and rollout.* - *Determine whether to create another committee to discuss the District's Data Map initiative or add to the Sustainability Subcommittee's Charter.*
7. Report from Sustainability Subcommittee	Ms. Rein presented highlights of the Sustainability Committee Board Chair Report, most notably that that the Subcommittee unanimously approved its charter. She reported that the Subcommittee had an engaged discussion on a number of key issues that revealed a lack of complete understanding of our current HIE assets. There was discussion about the need to build a sustainability model that brings in other payers and is not solely focused on Medicaid. Mr. Botts warned against including too many individuals by creating a Subcommittee that

	would be the same size as the full Board. Ms. Rein said that the next major agenda item for the Subcommittee should be to discuss how to engage private payers. Mr. Palmer sent a list of commercial payer contact persons to Mr. Botts. Dr. Freeman mentioned that the Board once had a commercial payer representative by the name of Wayne Cohen and that he might be interested in joining again if we presented him with a high value proposition. Ms. Rein continued her report, referencing the Subcommittee's discussion about the composition of the group and reporting that the Subcommittee decided that it would be beneficial to include at least one additional individual with a financial background. Ms. Rein continued, saying that the Board needs to do a mini-analysis of the financial drivers of the District's current HIE environment. Ms. Cronin suggested that the Subcommittee identify the key financial issues that are preventing key players such as MedStar and MFA from contributing labs and actively participating with HIEs, because without adding value for these major players, the HIE will not be as successful as we would like. He then seconded notion and called for a vote. The motion passed unanimously. Mr. Botts reminded the Board that, per the Bylaws, must set the frequency and sunset date of Sustainability Subcommittee meetings. Ms. Rein suggested that the committee meet every 6-8 weeks. Mr. Botts suggested that it meets at least once between each Board meeting with the ability to meet more frequently. Dr. Nesbitt said that more frequent meetings are necessary; the HIEPB has been held back due to a lack of Sustainability Subcommittee meetings. Dr. Sorel said that having more frequent Subcommittee meetings is necessary but insufficient to advance the mission of the Board. He said that all major stakeholders, especially those that pay the bills (especially private payers), need to be included either by being on the subcommittee and/or by being invited to Subcommittee meetings to present. Ms. Schlosberg recited the list of major private payors in the District: BCBS, Kaiser, and Aetna. She said that these payers need to be included in discussions to some extent moving forward. Mr. Botts made a motion to have a minimum of four Subcommittee meetings each year with one between each HIEPB meeting. The motion was seconded and then amended by Ms. Rein who proposed that the Subcommittee have a minimum of six annual meetings with the opportunity for the Subcommittee Chair to add additional meetings. The motion carried unanimously. *Action Items:* *-The Subcommittee shall perform an analysis of financial drivers of HIEs within the District.* *-The Subcommittee shall discuss private payer engagement strategies.* *-The Subcommittee shall reach out to non-Board members, specifically those with financial or private payer expertise, to inquire about their interest in joining this Subcommittee.*
8. Effects of MACRA/MIPS on HIE Landscape	Ms. Cronin began her presentation on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation which, she explained, includes a Quality Payment Program comprised of two paths: 1) Merit-Based Incentive Payment System (MIPS) and 2) Alternative Payment Models (APMs). The legislation passed after HHS Secretary Burwell had put forward goals that by 2016 30% of all Medicare payments would be through APMs and that by 2018 50% of all payments would be through APMs. Medicare has already surpassed the 30% benchmark and is on track to meet the 50% benchmark. Medicare is moving quickly towards APMs, away from FFS,

	which is rapidly accounting for a good chunk of Medicare beneficiaries. MACRA will have great impact beyond Medicare as it repeals the Sustainable Grown Rate (SGR). The legislation consolidates programs that already existed including Value Based Modifiers and Meaningful Use, collapsing all programs into one bucket called MIPS. Physicians can be in four buckets: 1) in MIPS and not in an APM, 2) in MIPS and in an APM, 3) in an Advanced APM and not in MIPS, 4) in an Advanced APM and in MIPS. As proposed in the NPRM, most of the nation's 800,000 physicians will participate in MIPS by 2017 and over time CMS expects these physicians to transition to Advanced APMs. The Advanced APM program offers a 5% bonus on top of other incentives to physicians who are succeeding in the APM. CMS and ONC expect a big shift from MIPS into APMs over the coming years. The first track of Medicare Shared Savings program, which includes many ACOs, is an example of the second bucket (above) and does not place the ACO at risk of losing money through the shared risk arrangement. Dr. Sorel asked about the qualifications to participate in these programs. Ms. Cronin stated that everyone in an ACO must meet qualified participant thresholds as defined by either patient counts or revenues. For an entity to qualify as an ACO under the Medicare Shared Savings Program (MSSP), the entity must maintain a minimum of 5,000 patients across its entire provider network. Ms. Schlosberg added that when CMMI came out with numbers on the participation of the Dual-Eligible population, CMMI said that DC is too small to participate in the program. Ms. Cronin said that many models are currently in their testing phase. If these programs succeed (by demonstrating improved quality and/or reduced cost), e.g. MSSP, then the program will be open to everyone across the nation as a permanent program. Ms. Cronin walked the Board through how a composite score is determined to generate MIPS payments. 50% of the score is determined by quality, 10% by cost, 15% by clinical practice improvement activities, and 25% by advancing care information. The composite score can range from -4 to +4 and increases over time to +/-9. It presents a strong incentive to perform well across all four categories. Dr. Freeman asked if the composite score is adjusted for the presence or absence of HIE infrastructure. Ms. Cronin acknowledged that this is a challenge but that the program is creating incentives for providers to invest in HIE infrastructure so as to benefit from the MIPS incentive structure. She continued, stating that a physician might be willing to pay for a technology solution or for a licensing fee to connect to a HIE if those investments will help the practice earn more money. The MACRA statute, as proposed, requires that a Qualifying Participant (QP) in an Advanced APM use CEHRT along with taking on more than nominal risk. CEHRT is therefore not only for MU, but also for APMs. This is intended to reinforce adoption of CEHRT that can result in added value through HIT for all providers. When Ms. Cronin introduced the topic of private payer or Medicaid APMs being used to qualify a physician to be a QP, Ms. Schlosberg asked for clarification about who can participate in which program and when. Ms. Cronin said that most providers would participate in MIPS, while some would qualify to be a QP in an Advanced APM. An example of an APM is the Comprehensive Primary Care Plus (CPC+) initiative, which is a PCMH-like model that is intended for group practices that include more than 50 physicians, with the idea being that such groups would have access to a greater amount of capital that can be used to invest in necessary (HIT) infrastructure. Some providers may choose to be in an ACO and may not wish to elect to use the Medicare-only

	calculation. Instead they would use an all payer calculation. Starting in 2021, some arrangements with other non-Medicare payers can count toward becoming a QP if the APMs use CEHRT (which would help facilitate HIE), quality measures, and share an appropriate amount of financial risk. Dr. Freeman asked if CEHRT loses its certification over time and if, in order to participate in an APM, it would be necessary to upgrade to the most recent edition of a CEHRT with the same vendor. Ms. Cronin said that 2015 CEHRT has improved standards that provide improved utility with the data that will make it easier to practice medicine. Adding to Dr. Freeman's concerns that physicians will have to bear undue costs associated with successively upgrading CEHRT, Dr. Sorel said that in other advanced economies physicians do not pay the costs of upgrades and the government does. Ms. Cronin said she just met with her counterparts in Germany and that the U.S. offers more incentive payments than any other nation in the world, implying that these incentive payments essentially pay for the cost of upgrading the CEHRT. Ms. Schlosberg encouraged Board members to submit comments to HHS on the proposed rule. Ms. Rein reinforced Ms. Cronin's comment, stating that AIU/MU incentives are in place to compensate for the costs of CEHRT upgrades. Dr. Freeman disagreed, stating that costs to providers often exceed payments from CMS. Ms. Cronin continued, stating that the ONC has been trying to help a number of states pursue a multi-payer approach to scaling HIE infrastructure. She emphasized the importance of thinking about what will really be valuable to physicians as new payment models are considered. Physician engagement is essential to the success of meaningful use of CEHRT, so CMS is attempting to develop APMs that incorporate CEHRT into physicians' workflows, leverage current assets such as the MDW, and act as a trusted neutral convener to improve value through HIT in American medicine.
9. Board Mission, Objectives & Milestones for FY16-17	Lastly, Mr. Botts directed the conversation to the draft HIE mission statement and Board objectives and milestones for FY16-17. Dr. Sorel said that HIE offers the promise of integrating systems; he asked if HIEs in the District would be capable of integrating care across healthcare specialties. Mr. Botts affirmed that they would. Ms. Cronin said that outside of highly integrated health systems, where primary care and specialty care are on the same platforms, the intent of HIE is to create virtual care teams. HIEs have mostly been transaction based to date but the goal would seem to be to create a common platform to create a shared care plan and to coordinate patient-centered care. Dr. Nesbitt said the HIE mission does not mention public health, which clearly was one of the primary goals of the HIE when the Board was originally created. Mr. Botts replied that of it was his believe that 'health disparities' accounts for public health; however, Dr. Nesbitt disagreed, articulating her opinion that public health be explicitly included in the mission. Dr. Freeman asked whether we could add the words 'and in the surrounding region' at the end of the mission since we are seeking to create a regional collaborative. Dr. Sorel asked that the phrase 'integrated care' be included in the mission. Ms. Rein asked that the mission be kept crisp and outcomes-oriented. Dr. Diop said that the first phrase needs to be preceded by an aspirational statement such as "The mission of the HIE is to improve the health of the residents of the District through…". Mr. Botts moved the conversation to the draft objectives and milestones for the remainder of FY16 through the end of FY17 emphasizing

	the need for the Board to coordinate its actions with both local and national efforts, including those highlighted in the District's State Health Innovation Plan (SHIP) and ONC's Interoperability Roadmap, among others. Mr. Botts asked the Board to agree upon specific, actionable items to which it can be held accountable, which were presented as draft objectives and milestones. Ms. Rein asked whether there was any significance to the order of the objectives and Mr. Botts replied in the negative. Dr. Sorel added that he thought the Board needed to identify strategies to proactively improve health as he believes our current healthcare system is designed to deal with illness, not with the promotion of health. Dr. Nesbitt responded that the Board has the opportunity to endeavor to make the HIE more about health rather than illness. She continued that the Board should vote on goals and milestones that reflect an HIE that promotes health rather than perpetuate an illness-centric approach through the creation of a long-term plan. Ms. Cronin stated that there are efforts already underway to do just that. For example, the eCQMs associated with MACRA are primarily prevention measures with population health applications that do address Dr. Sorel's request that new models of care be proactive in promoting health. Dr. Chapman stated that 80% of outcomes are outside of healthcare facilities and that it seems as though the Board is building a system that will connect healthcare institutions to each other, which does not help 60% of the general patient population that misses their appointments and never enters a formal healthcare setting. He encouraged the Board to find out what motivates patients to go to the doctor's office and that the Board should identify strategies to make more connections with the community. Mr. Botts said that he agrees with that sentiment; however, he added that HIEs are a tool and cannot be looked at to solve every issue facing healthcare today on their own. *Action Items:* *-The Board shall review the draft mission statement, objectives, and milestones set forth by the Chair and provide feedback to the Chair prior the next Board meeting.*
10. Adjournment	Mr. Botts reminded the Board that the next meeting will be held on September 15, 2016 and he adjourned the meeting at 4:02pm.