DC HIE Policy Board

June 23, 2016

TOPICS FOR DISCUSSION

1) Updates on Current HIE Initiatives
2) Report from Sustainability Subcommittee
3) Potential Effects of MACRA/MIPS on District HIE Landscape
4) Board Objectives and Milestones for FY16-17
5) Feedback on District's State Health Innovation Plan (SHIP)

UPDATES ON CURRENT HIE INITIATIVES

IAPD-U FOR FY16-17

- *REMINDER*: 5 IAPD-U Initiatives
  1) Dynamic Patient Care Profile
  2) eCQM Dashboard
  3) OB/Prenatal Registry
  4) Analytical Population Dashboard
  5) Support for Increased Ambulatory Connectivity
- CMS HITECH team pre-reviewed IAPD in May
- Formal Submission submitted on June 1st
- Targeted Approval: Early/Mid-July

DISTRICT HIE DESIGNATION

- *REMINDER*: Developing a formal HIE Designation process
  - Create a more cohesive HIE ecosystem
  - Standardize min. capacities/functionality of HIEs operating in the District
- Researching designation requirements to consider
  - 6 categories: 1) *Accreditation/Certification*, 2) *Business Operations*, 3) *Performance & Monitoring*, 4) *Policies & Procedures*, 5) *Security & Encryption*, and 6) *Technical Tools/Standards*
  - Particularly focused on MD, NY, PA, and TX
- Targeted Implementation: Spring/Early Summer '17

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DC HIE Data Summary

For Authorized Use Only – Confidential

June 23, 2016

Goals and Objectives

Goal: Gain foundational understanding of available data, where it's stored and barriers to data exchange within the District

Objectives

Collaborate with key stakeholders to gain pertinent information

Document health data flow within the District at both a high level and technical view

Highlight key opportunities for enhanced data flow

Improved Data Access

Increased Collaboration

Data Sources and Data Stores Reviewed

Point-of-Care Data *Sources*

- Hospitals
- Ambulatory Clinics
- Ancillary Services
  - Laboratories
  - Radiology Centers
  - Pharmacies
- iCAMS

District Data *Stores*

- Medicaid Claims and Administrative Data
- Case Management
- Public Health Registries
- Annual Hospital Discharge Database
- Surveillance Database
- iCAMS

HIE Data *Stores*

- Capital Partners in Care (CPC)
- Children's IQ Network
- CRISP HIE

Current State of Information Exchange

PROBLEM STATEMENT:

Data availability depends on where care is sought

- Data access and connectivity among data users is inconsistent throughout the District → *Lack of EHRs or access to Health* IT; *EHRs not connected to HIE*; *HIEs not connected to each other*

PROVIDER IMPACT:

- Prevents effective participation in value-based payment models
- Impacts care coordination and delivery of quality, safe, effective care

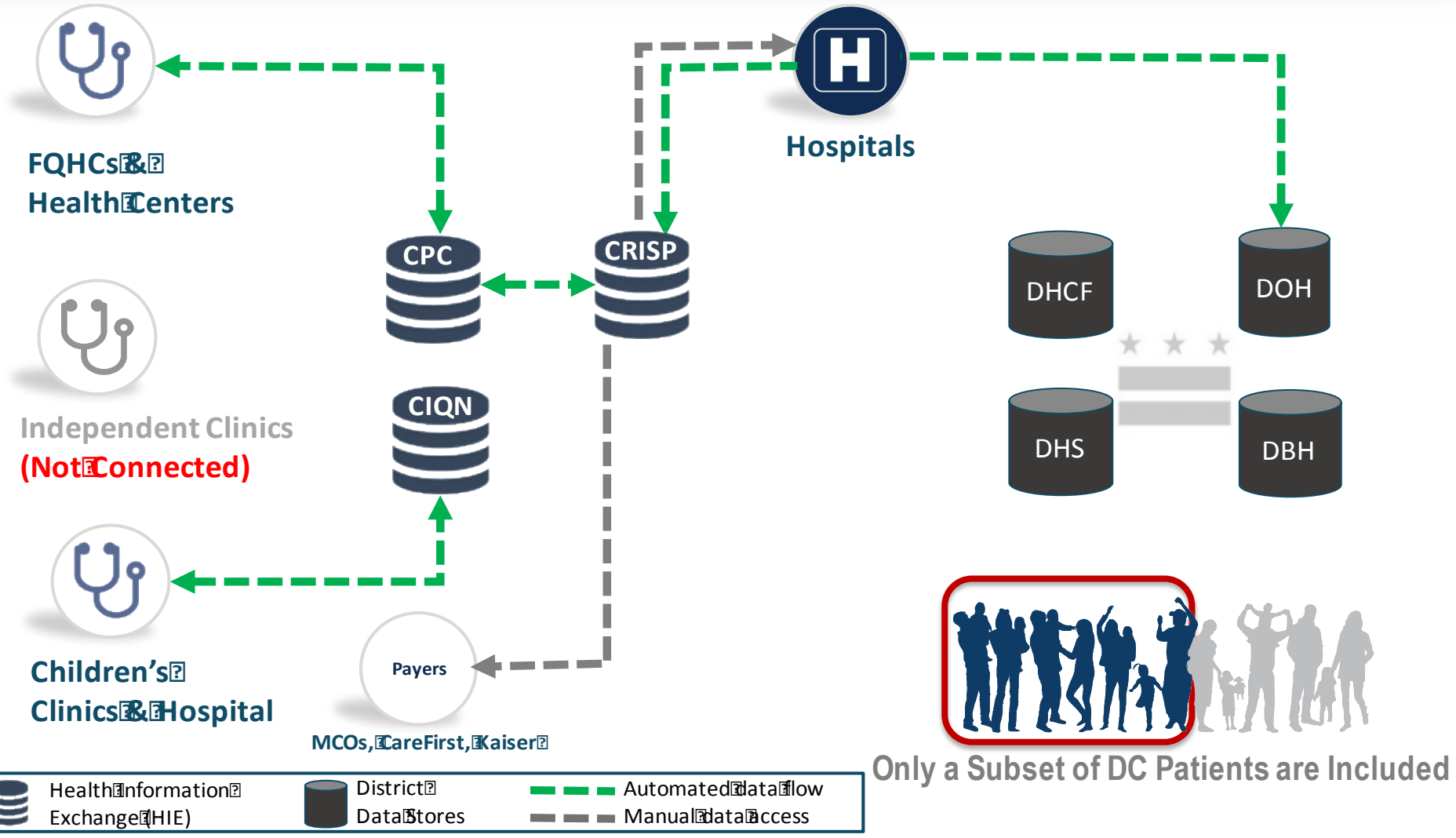
DC GOVERNMENT IMPACT:

- Inability to develop population health services
- Limited ability to develop effective care and payment programs (e.g. health homes)
- Needs of most underserved population are not identified nor met

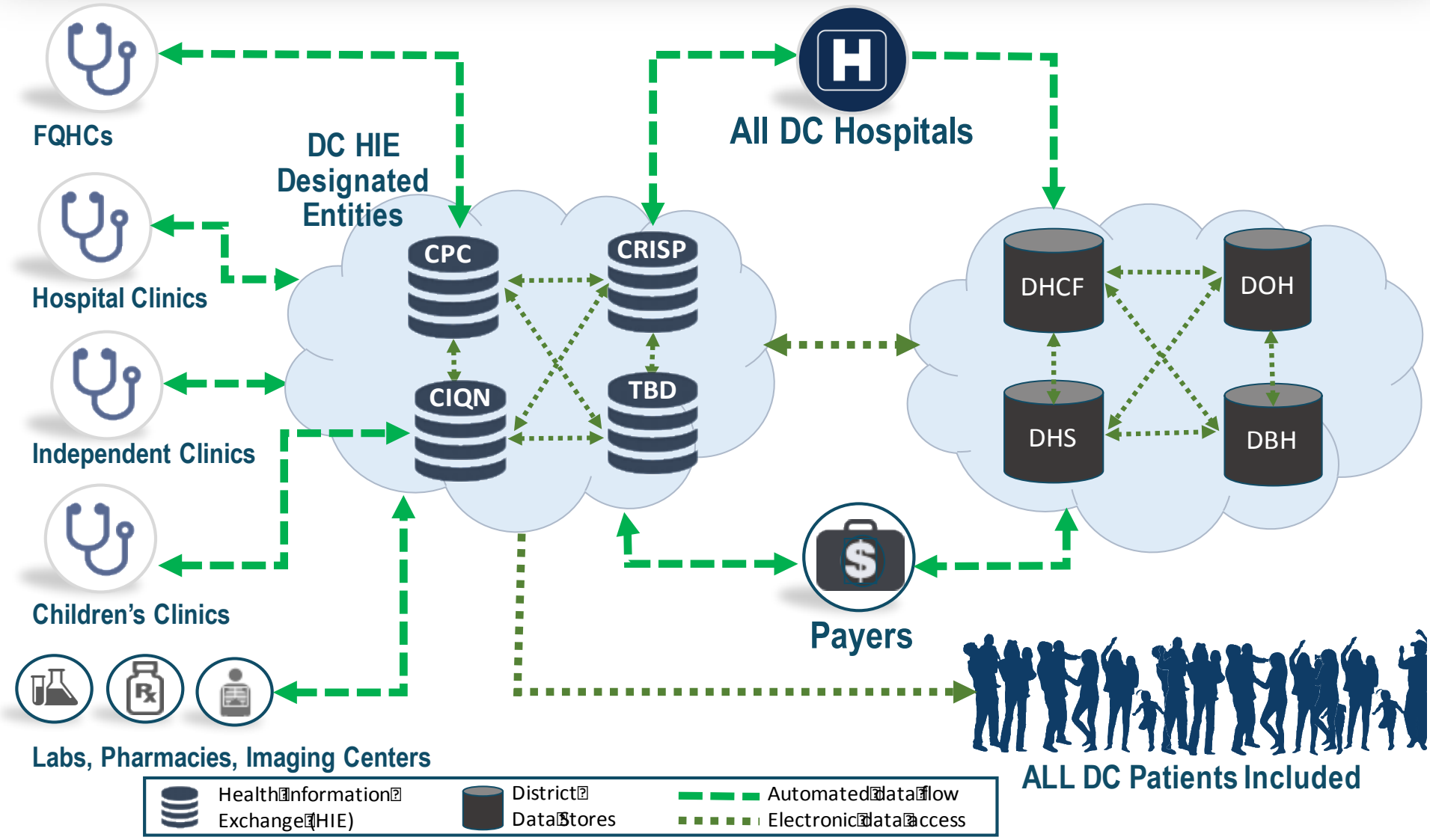
PATIENT IMPACT:

- Increased potential for duplicate or inappropriate treatment or testing
- Limits self-advocacy

Current State



Potential Future State
(For Illustrative Purposes Only)



Future State of Information Exchange

VISION:

By 2021, a foundation for DC HIE Ecosystem serves ALL District residents.

- ***ALL*** patients
- ***ALL*** clinics
- ***ALL*** hospitals
- ***ALL*** payers

PROVIDER IMPACT:

- Enables participation in quality and value-based care programs
- Facilitates safe and effective care delivery at the point of care
- Data integration for effective practice-based and hospital-based population health

DC GOVERNMENT IMPACT:

- DC has the ability to *access* and *use* all health data for patients
- DC can determine unmet needs and develop effective programs

PATIENT IMPACT:

- Care is coordinated amongst all providers who care for a patient
- Patients have access to their health information to engage in care
- Improved health outcomes

District Data Flows

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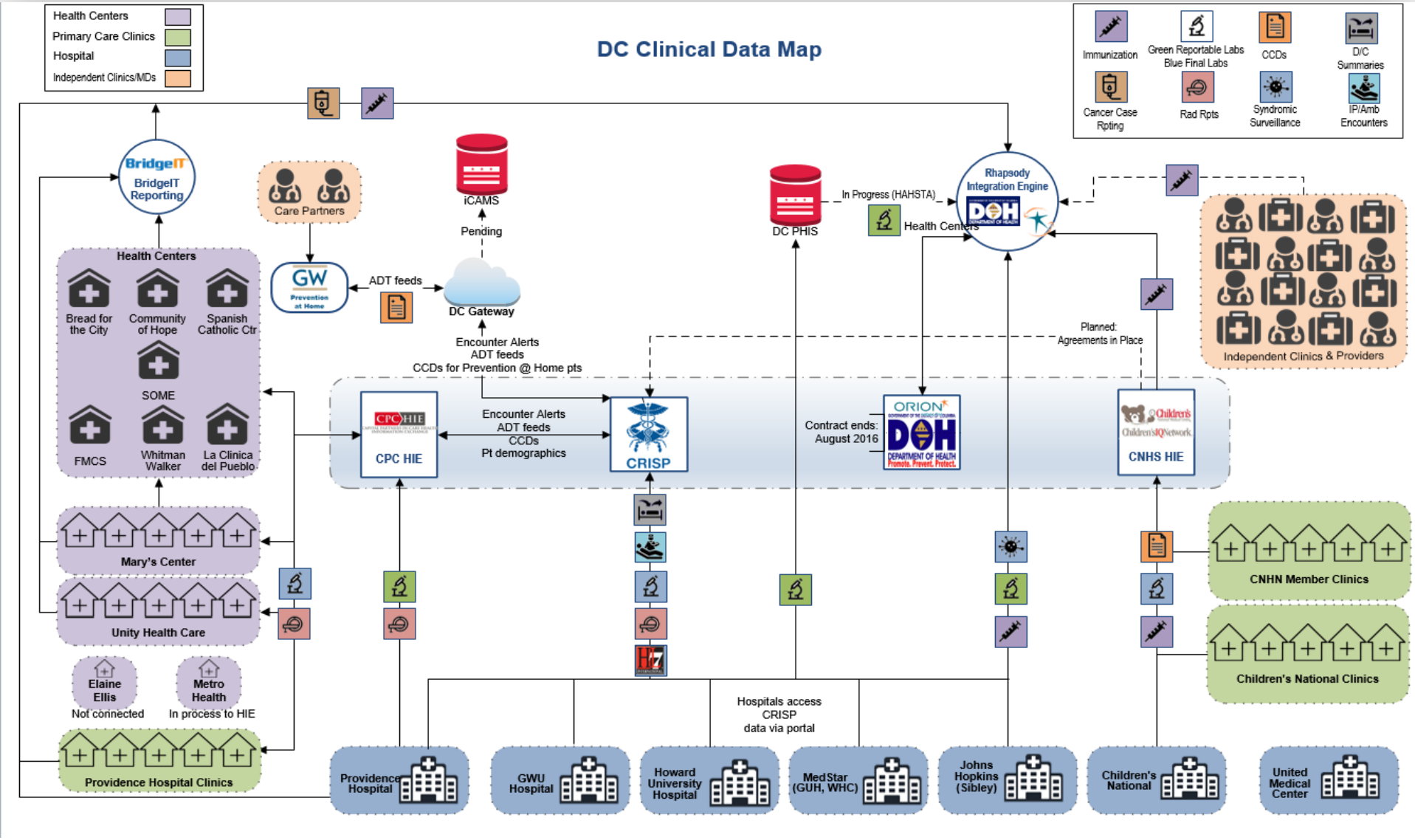
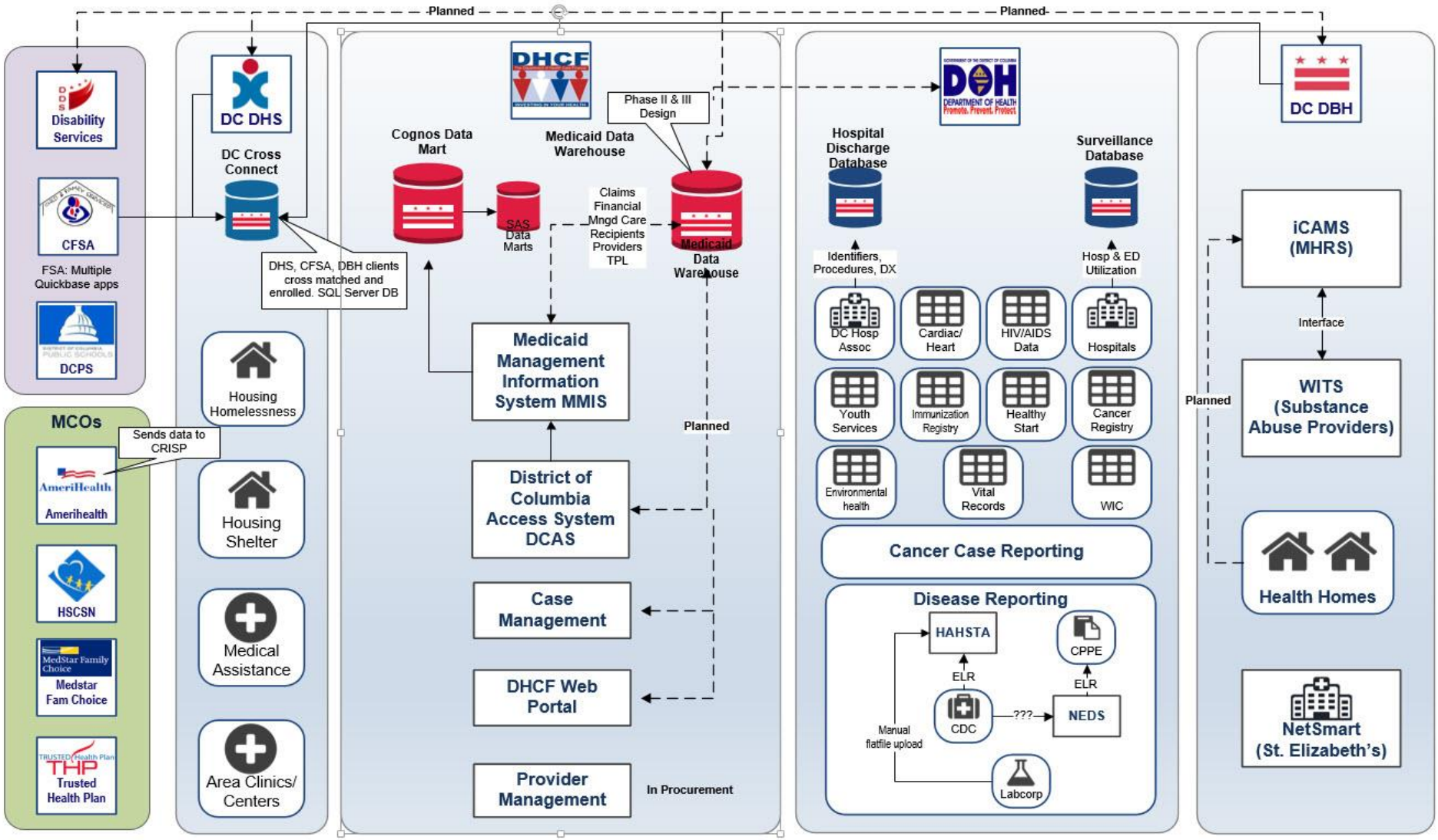
Clinical Data Exchange – Icon View *(Draft)*



DC Government Data Exchange *(Draft)*



Data Availability for HIE: Current State

			Data Exchanged							HIE or Repository With Data				
Org/Group	Inpt/Amb	EHR/Health IT	CCDs	Lab	Rad	Cancer Ca	Ix	ELR	Syndrom	CPC	CRISP	GW P@	CIQN	DOH Or
Bread for the City	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Community of Hope	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Elaine Ellis	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Family & Medical CS	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
La Clinica del Pueblo	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Mary's Center	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Metro Health	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
SOME	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Whitman Walker	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Planned Parenthood	Ambulatory	NextGen	NO	NO	NO	NO	NO	N/A	N/A	NO	NO	NO	NO	NO
Unity Health Care	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Providence Clinics	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	YES	ENS Panel	YES	NO	YES
Children's Clinics	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	NO	NO	NO	YES	YES
Peds Clinics - CNHN	Ambulatory	eCW	YES	YES	YES	YES	YES	N/A	N/A	NO	NO	NO	YES	YES
MedStar Clinics	Ambulatory	GE Centricity -> Cerner	NO	NO	NO	UNK	YES	N/A	N/A	NO	NO	NO	NO	YES
Howard Clinics	Ambulatory	Allscripts Enterprise	NO	NO	NO	UNK	YES	N/A	N/A	NO	ENS (IN PROG)	NO	NO	YES
GWU Clinics (MFA)	Ambulatory	Allscripts Enterprise	UNK	UNK	UNK	UNK	YES	N/A	N/A	NO	ENS Panel	NO	NO	YES
UMC Clinics	Ambulatory	eCW (Implementing)	NO	NO	NO	UNK	UNK	N/A	N/A	NO	NO	NO	NO	NO
Johns Hopkins Clinics	Inpatient	Epic	NO	NO	NO	UNK	YES	YES	YES	NO	ADT, Lab, Rad	NO	NO	YES
MedStar Georgetown Hosp	Inpatient	Cerner	NO	NO	NO	UNK	YES	YES	YES	NO	ADT, Lab, Rad	NO	NO	YES
MedStar Wash Hosp Ctr	Inpatient	Cerner	NO	NO	NO	UNK	YES	YES	YES	NO	ADT, Lab, Rad	NO	NO	YES
GWU Hospital	Inpatient	Cerner	NO	YES	UNK	UNK	YES	YES	YES	NO	ADT, Lab, Rad	NO	NO	YES
Johns Hopkins - Sibley Hosp	Inpatient	Epic	NO	NO	NO	UNK	YES	YES	YES	NO	ADT, Lab, Rad	NO	NO	YES
Howard Univ Hospital	Inpatient	Siemens	NO	NO	NO	UNK	YES	YES	YES	NO	ADT, Lab, Rad	NO	NO	YES
Providence Hospital	Inpatient	MEDITECH	NO	YES	YES	UNK	YES	YES	YES	YES	ADT, CCD, Lab, Rad	YES	NO	YES
Children's National	Inpatient	Cerner	YES	YES	UNK	UNK	YES	YES	YES	NO	NO	NO	NO	YES
UMC Hospital	Inpatient	MEDITECH	NO	NO	NO	NO	UNK	UNK	UNK	NO	NO	NO	NO	UNK
Ind Practices Achieving MU	Ambulatory	Various	NO	NO	NO	UNK	YES	N/A	N/A	NO	Varies	NO	NO	YES
Ind Practices Not Achieving MU	Ambulatory	Various	NO	NO	NO	NO	Varies	N/A	N/A	Varies	Varies	Varies	Varies	Varies
Ind Practices Without EHRs	Ambulatory	None	NO	NO	NO	NO	NO	N/A	N/A	NO	NO	NO	NO	NO
GCM Radiology	Imaging Ctr	Unknown	N/A	N/A	YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Foxhall MRI (Progressive Rad)	Imaging Ctr	Unknown	N/A	N/A	YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Washington Radiology Assoc	Imaging Ctr	Unknown	N/A	N/A	YES	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other / Ind Radiology Centers	Imaging Ctr	Unknown	N/A	N/A	NO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- **Data Exchanged:** Data types and formats available for exchange from Organization's EHR
- **HIE or Repository With Data:** Indicates where HIE or Data Store electronically receives data from Organization.
- **Values:** Yes; No; UNK = Unknown at this time; IN PROG = In Progress; Varies = Varies by individual Organization
- Data availability collected from interviews and review of available HIE documentation April/May 2016

Summary

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Summary: Data Flows (Integration)

Patients Served

- Current HIEs serve distinct patient populations
- Only a subset of patients served

CPC HIE

- FQHCs
- Providence Hospital

CNHS HIE

- Children's Hospital
- Children's Clinics
- Children's affiliated clinics

CRISP

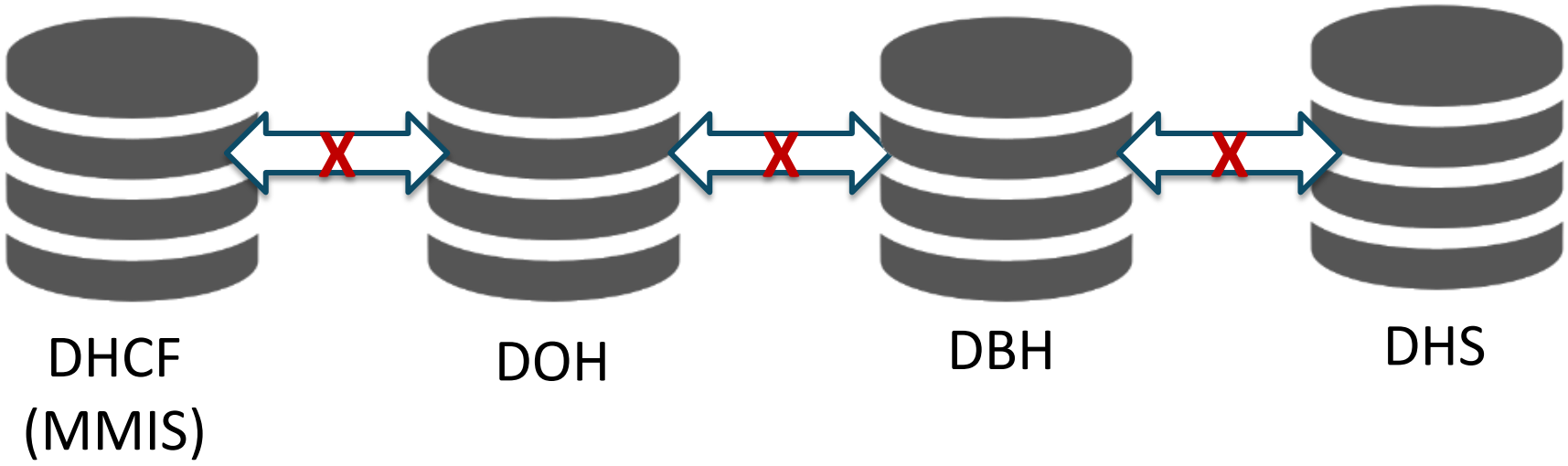
- 6 Out of 8 Hospitals

0% of HIEs Serve These Patients

Examples

- United Medical Center
- Independent Benning Rd, Anacostia Providers/Clinics

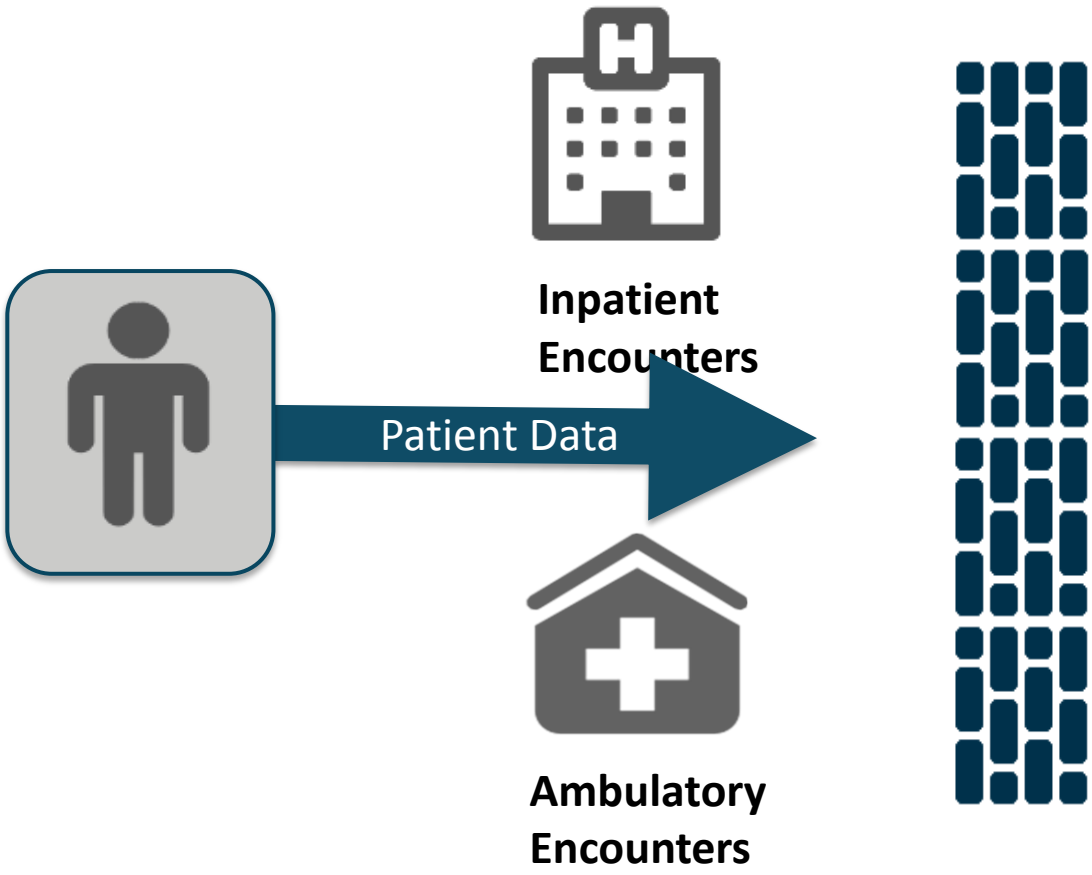
Summary: DC Data Stores (Examples)



- Medicaid Claims
- Case Management
- Hospital Discharge Database
- Surveillance Database
- iCAMS
- Housing

Illustrative Purposes Only – Data Store Listings Are Not Comprehensive (Examples)

Summary: Gaps and Barriers



Lack a Longitudinal View of Patient Encounters

- ED/Hospital encounters:
  - Until Children's National and UMC are connected via CRISP
- Ambulatory encounters:
  - Outside of FQHCs + Providence Clinics
  - Children's National has their own

Primary POC Contact Information:

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*Performed via Subcontract to Navigant Consulting
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REPORT FROM SUSTAINABILITY SUBCOMMITTEE

CURRENT MEMBERS

#	SUBCOMMITTEE MEMBER	AFFILIATION	BOARD MEMBER
1	**Alison Rein *(CHAIR)***	AcademyHealth	YES
2	**Claudia Schlosberg**	DC Dept. of Health Care Finance	YES
3	**Chris Botts**	DC Dept. of Health Care Finance	YES
4	**LaQuandra Nesbitt**	DC Dept. of Health	YES
5	**Andersen Andrews**	DC Dept. of Health	NO
6	**Donna Ramos-Johnson**	DC Primary Care Assoc.	YES
7	**Justin Palmer**	DC Hospital Assoc.	YES
8	**Peter Stoessel**	AmeriHealth	YES
9	**Scott Afzal**	CRISP	NO

SUBCOMMITTEE CHARTER

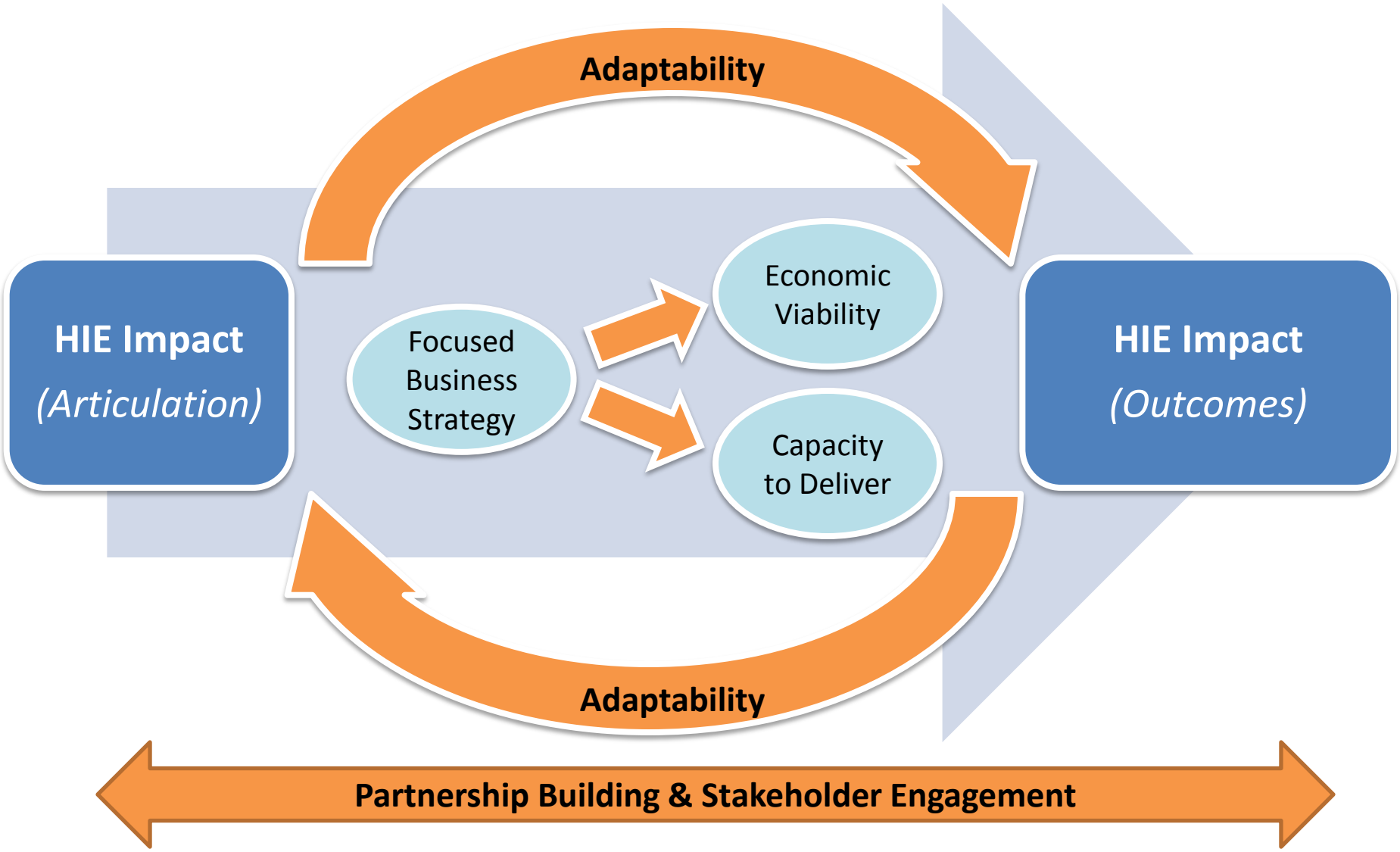
I. Purpose
   - Recommendations to Board representing best approach(s) to establishing long-term, sustainable HIE in the District

II. Composition & Meetings

III. Responsibilities & Duties
   - Analyze nationwide models and best practices
   - Discuss potential barriers and challenges
   - Recommendations for implementation

IV. Reports

APPROACH TO SUSTAINABILITY



Source: Robert Wood Johnson Foundation; Aligning Forces for Quality – Sustainability Framework

KEY QUESTIONS

- What value drivers are needed to encourage current and future HIE participation from stakeholders? How prescriptive should the District be in implementing such drivers?
- Which drivers currently exist in the District?
- Are there barriers and challenges to implementing such drivers?
- What are the various revenue sources that can be leveraged?
- How can these efforts support other payers?
- What model(s) can be tailored to fit the District's needs?

NEXT STEPS

- Determine meeting frequency and subcommittee sunset date
  - Per Bylaws, determined by Board
- Recruit additional member(s) representative of the following areas of expertise:
  - Economics/Finance
  - Independently Practicing Physicians
- Gather cost data related to high-value HIEs
- Discuss strategies around private payer engagement
- Review nationwide HIE models and their applicability to the District

MACRA/MIPS EFFECTS ON DISTRICT HIE LANDSCAPE

The Office of the National Coordinator for Health Information Technology

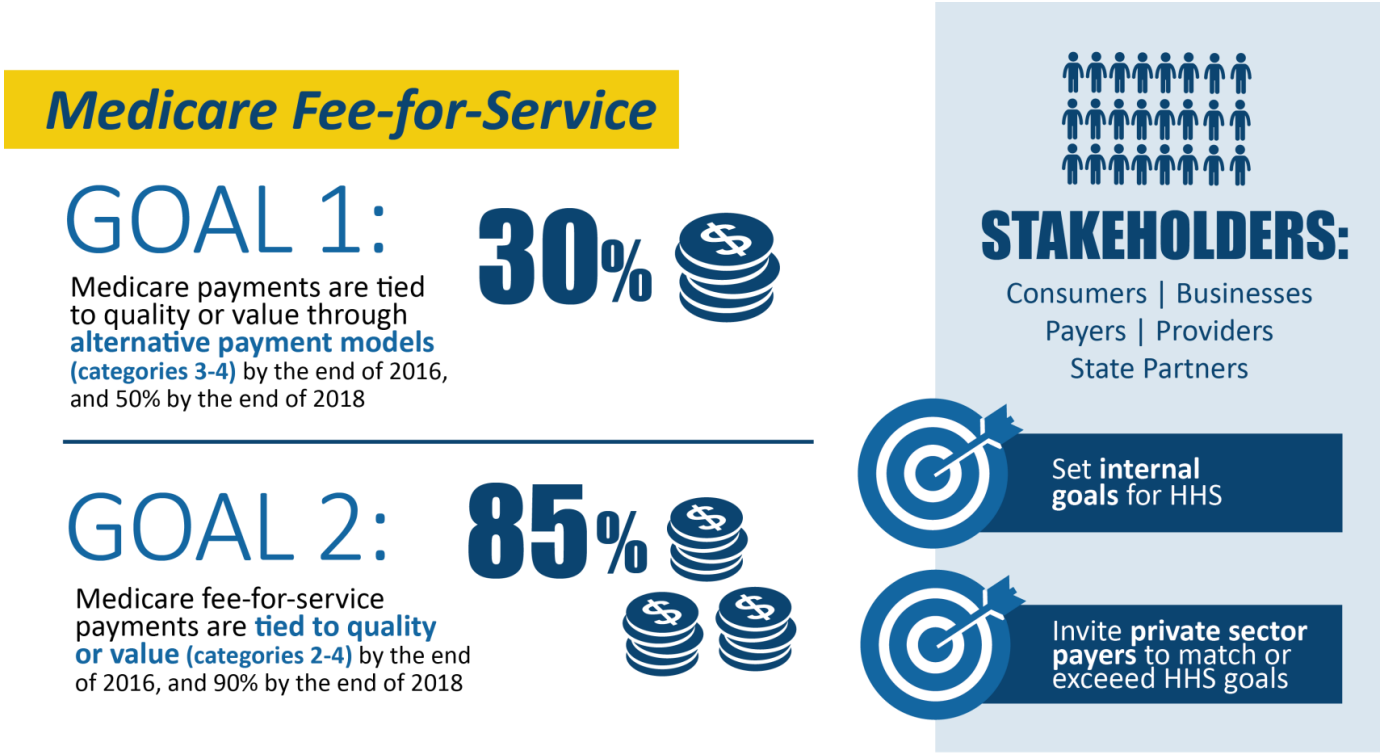
DC HIE Policy Board Meeting

June 23, 2016

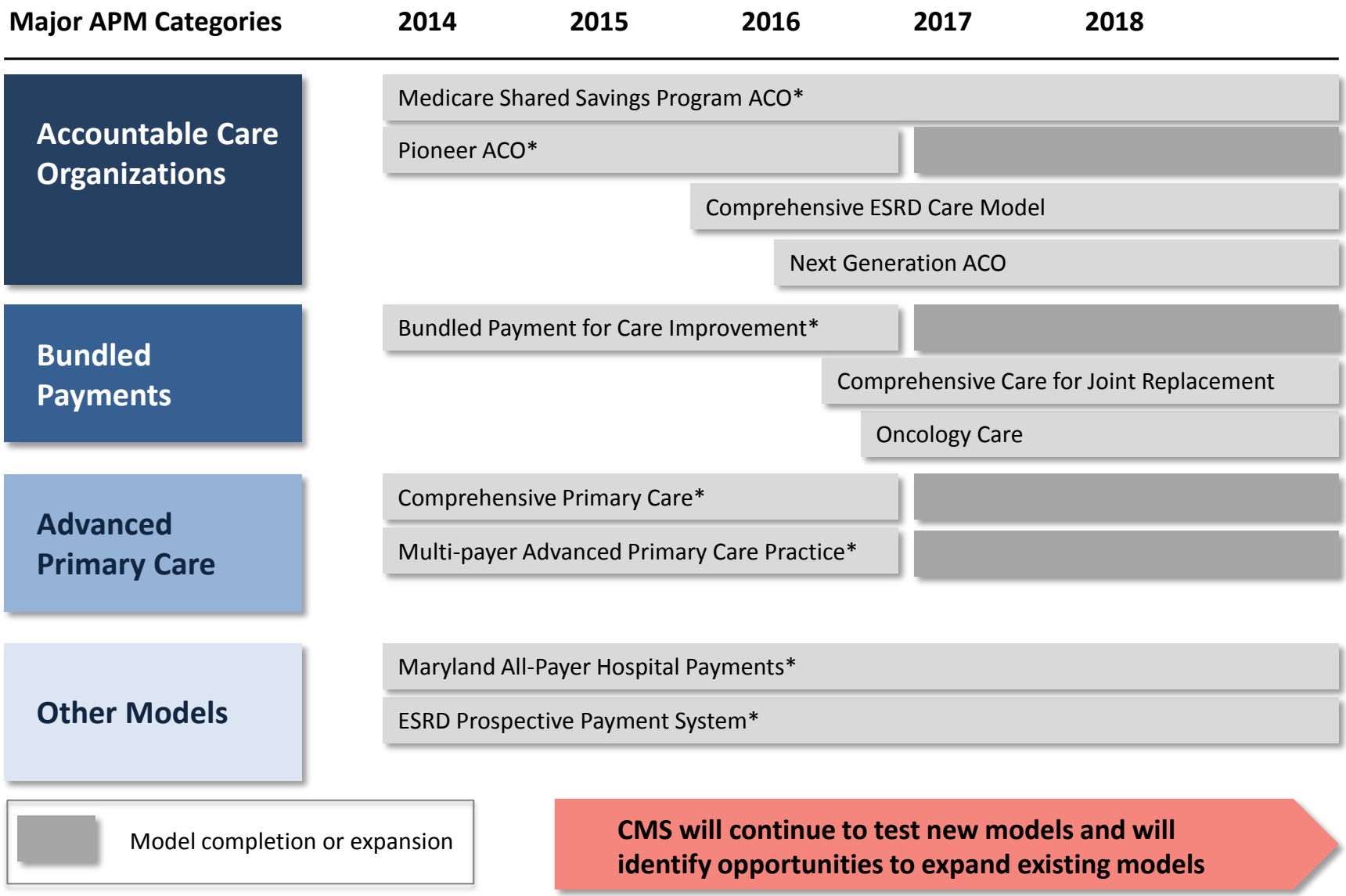
Kelly Cronin, MS, MPH, Director, Office of Care Transformation, ONC/HHS

HHS Goals for Medicare Payment Reform

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**



Medicare Met the Goal of 30% of Payments in APMs 1 Year EARLY



* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2012, MAPCP started in 2011, Maryland All Payer started in 2014 ESRD PPS started in 2011

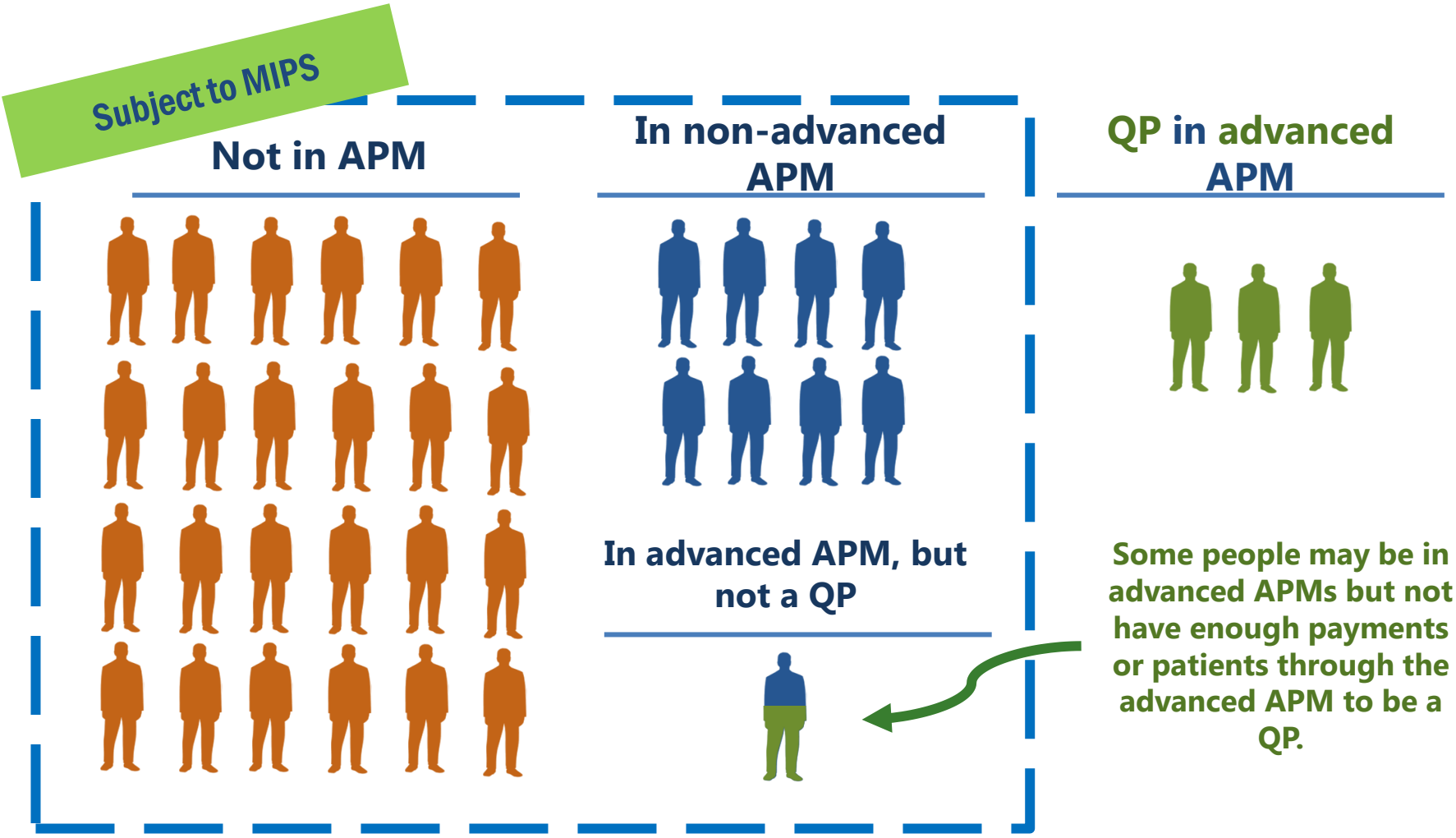
Medicare Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

The Merit-based Incentive Payment System (MIPS) **or** **Advanced Alternative Payment Models (APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

Most clinicians will be subject to MIPS.

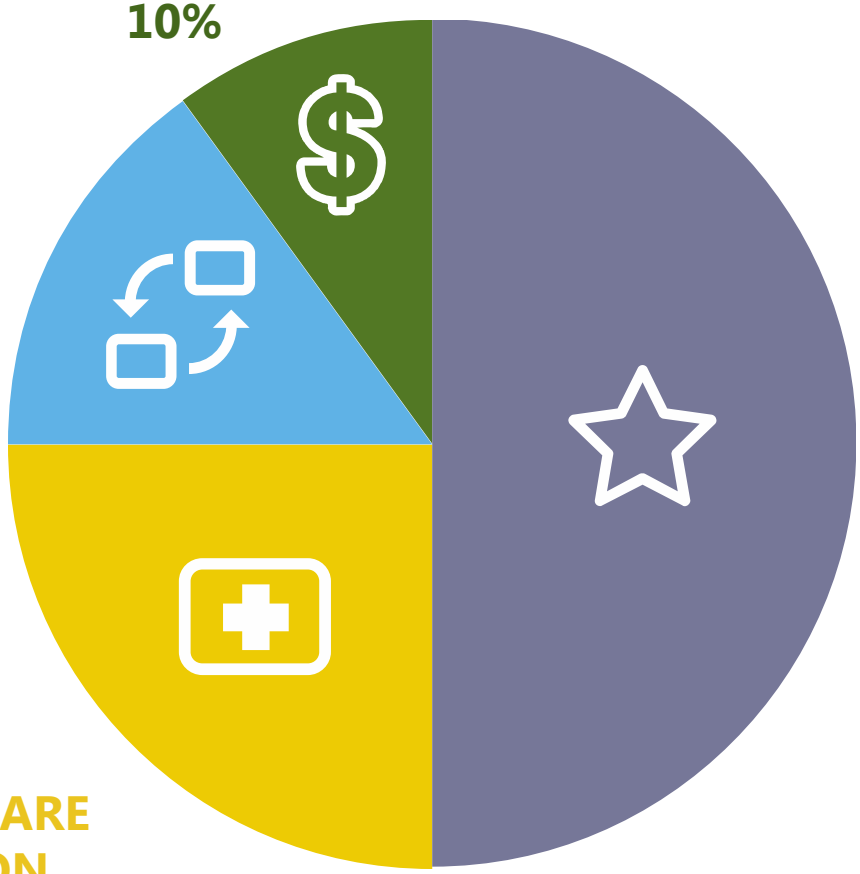


Note: Figure not to scale.

MIPS Performance Categories

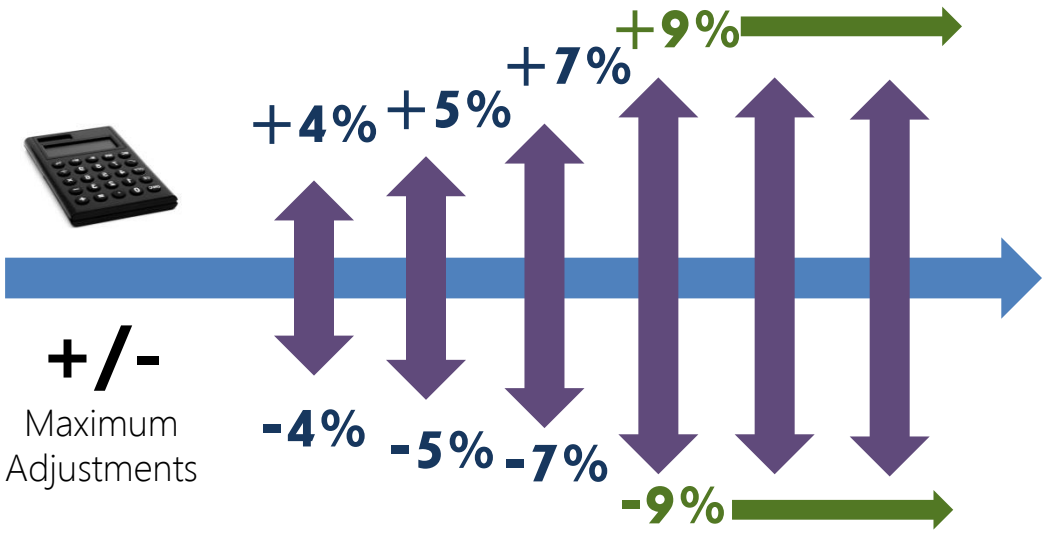
A single MIPS composite performance **score** will factor in performance in **4 weighted performance categories on a 0-100 point scale**:

Year 1 Performance Category Weights for MIPS



How much can MIPS adjust payments?

Based on a CPS, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.



Adjusted Medicare Part B **payment** to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

2019 2020 2021 2022 onward

Merit-Based Incentive Payment System **(MIPS)**

The Quality Payment Program provides additional rewards for participating in APMs.

Potential financial rewards

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**

Advanced APMs meet certain criteria.

As defined by MACRA, advanced APMs **must meet the following criteria**:

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

PROPOSED RULE

Advanced APM Criterion 1:

Requires use of Certified Health IT

Certified EHR use

Example: An Advanced APM has a provision in its participation agreement that at least 50% of an APM Entity's eligible clinicians must use Certified Health IT.

- ✓ An Advanced APM must **require at least 50% of the eligible clinicians in each APM Entity to use Certified Health IT** to document and communicate clinical care. The threshold will **increase to 75%** after the first year.
- ✓ For the **Shared Savings Program only**, the APM may apply a **penalty or reward** to APM entities based on the degree of Certified Health IT use among its eligible clinicians.

Proposed Rule
Advanced APMs

Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?

- ✓ **Shared Savings Program** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

What about private payer or Medicaid APMs? Can they help me qualify to be a QP?

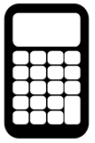
Starting in **2021**, **some** arrangements with other non-Medicare payers can **count toward** becoming a QP.

"All-Payer Combination Option"

IF the "Other Payer APMs" meet criteria similar to those for Advanced APMs, CMS will consider them "Other Payer Advanced APMs":

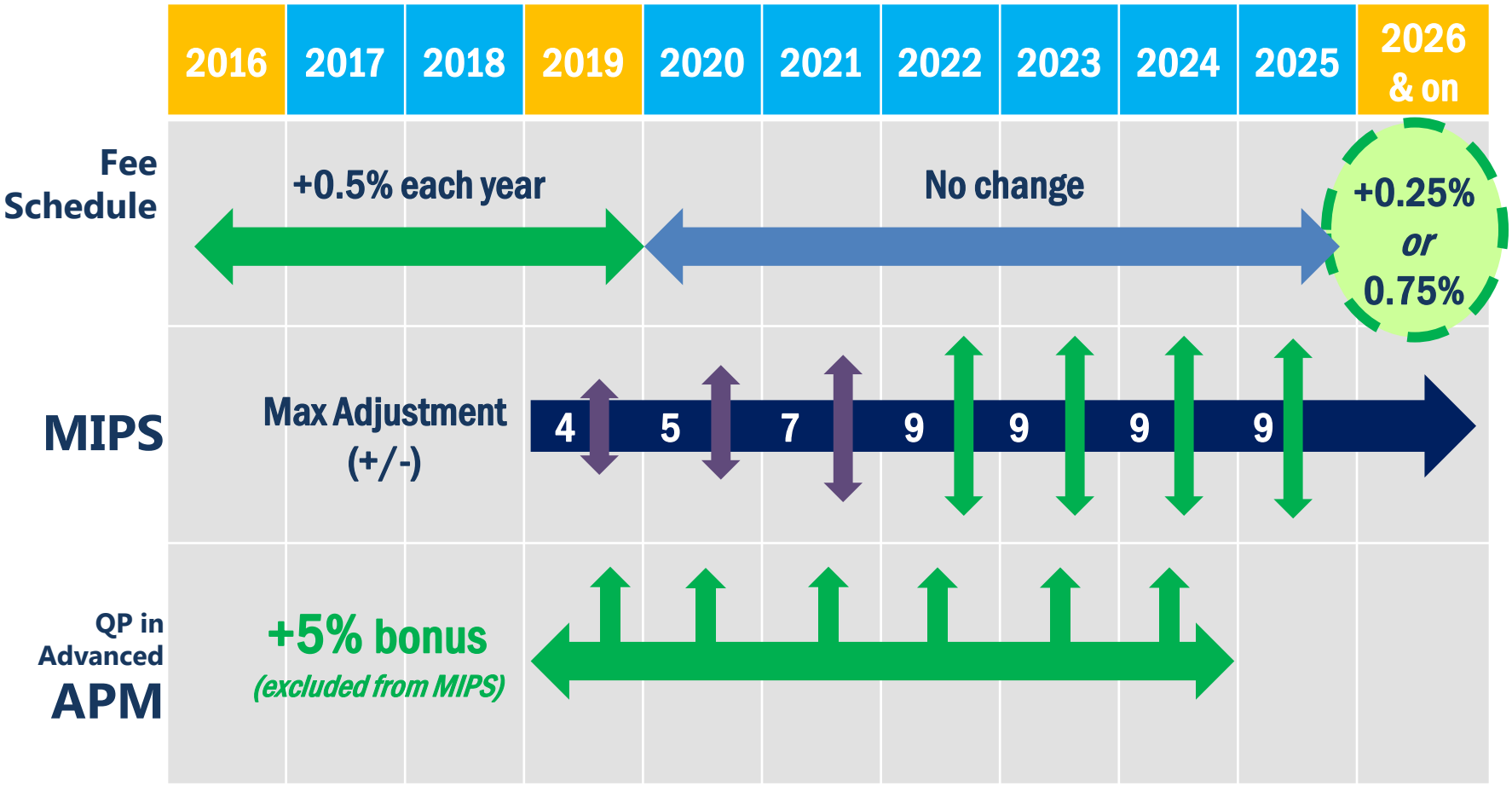
Certified EHR use

Quality Measures



Financial Risk

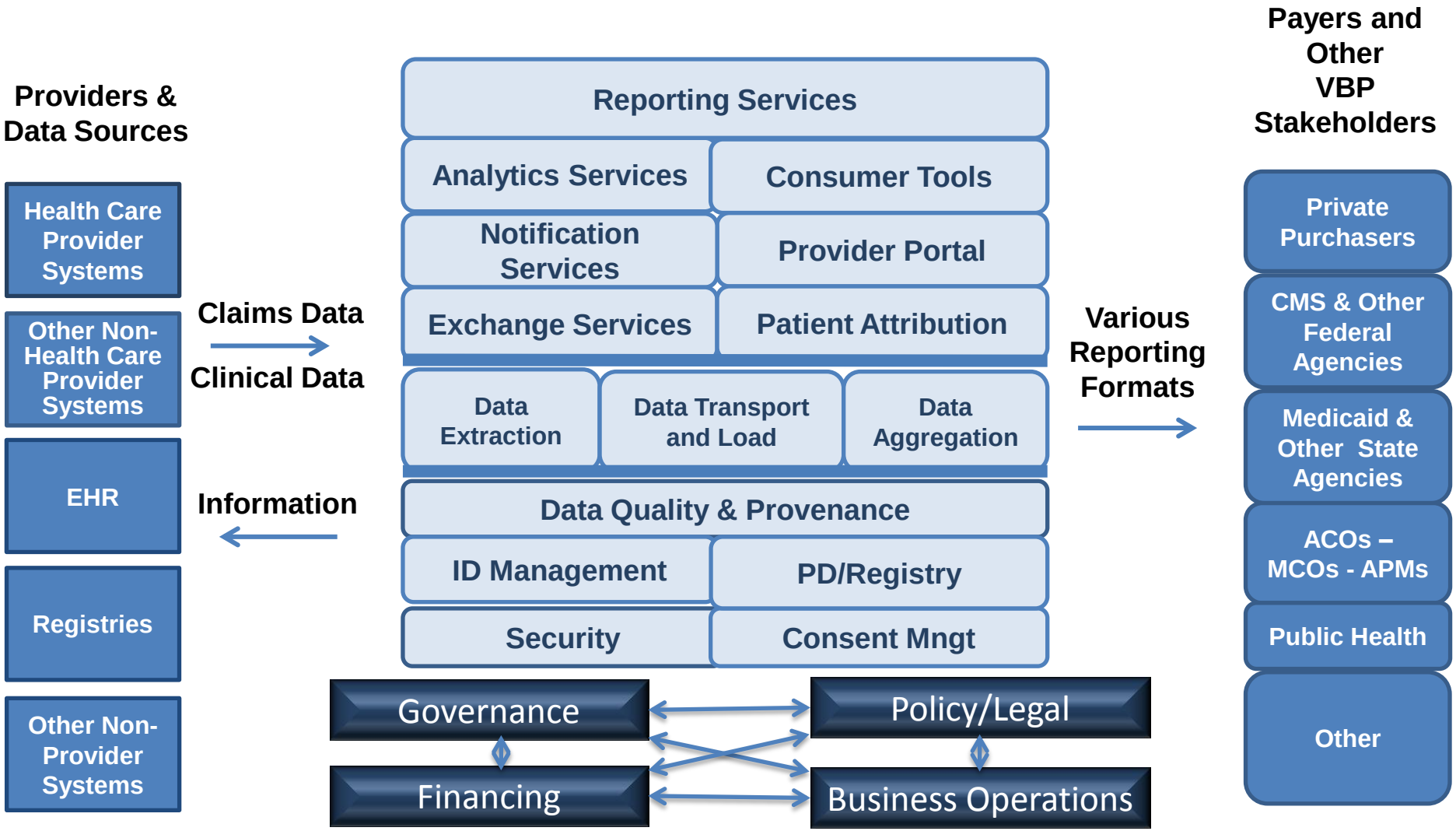
Putting it all together:



Medicare Payment Reform alone will not drive interoperability

- APMs offer a number of opportunities to reinforce the adoption of health information exchange capabilities and HIT tools that are instrumental to providers succeeding within these models.
- Advanced Medicare APMs will require use of certified health IT among eligible clinicians
- Multi-payer alignment of incentives or requirements for interoperability will drive provider behavior and uniform adoption of standards through certification.
- State policies will also reinforce interoperability through Medicaid waivers, State Plan Amendments (e.g., health home requirements), Managed Care Contract requirements, Medicaid matching fund policies, and other state driven mandates or incentives

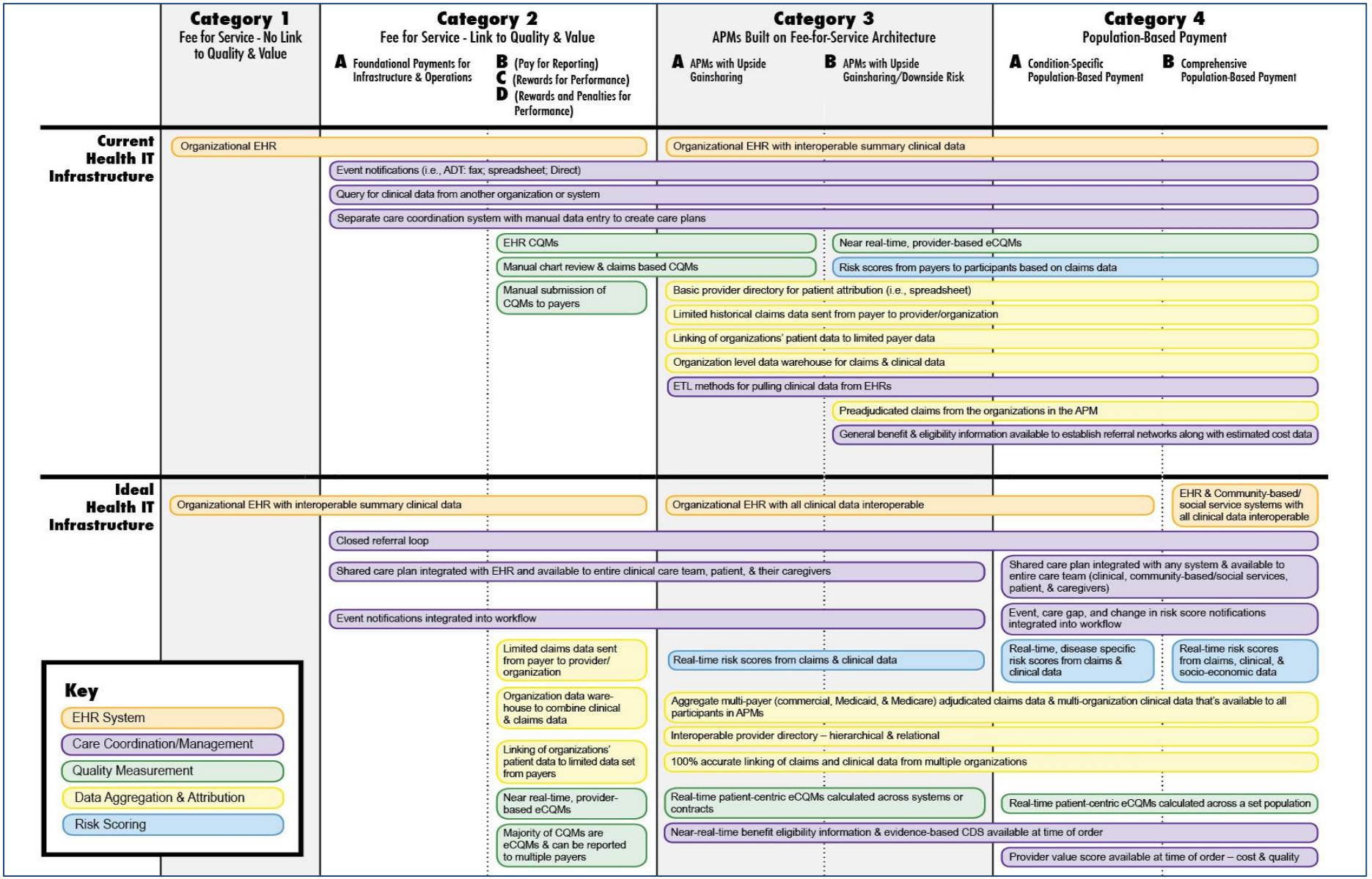
HIT Modular Functions for Value Based Payment



Key Insights from States on Multi-Stakeholder Collaboration for APM Data Infrastructure

- Focus on 1-2 high value use cases valuable to providers and payers, i.e., improve measurement, reporting and performance
- Assess existing data assets statewide (APCD, HIEs, CDRs, Medicare QEs, etc.) to determine if they meet requirements
- Need a neutral convener and facilitator
  - Starting with a multi-payer process with provider input has been effective
  - Find the right committed partners at the right level in respective payer organizations (senior level clinician managers)
  - State shouldn't necessarily lead but definitely be at the table and fully engaged
- Keep process nimble, flexible, informal initially
- Get front line clinician input into user design of reporting tools to ensure value and usability in practices
- CMS Data Use Agreement can permit access to Medicare data for APMs like CPC

Health IT and APM Framework



The Office of the National Coordinator for Health Information Technology

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BOARD OBJECTIVES & MILESTONES FOR FY-16-17

DISTRICT'S HIE MISSION

Reduce health disparities, improve health outcomes and better health care delivery by enabling the secure and cohesive exchange health information in the District of Columbia.

OVERALL HIE GOALS

- Allow health-related data to be accessible and actionable at the *right place*, at the *right time*, and in the *right format*

- Integrate traditional *data silos* into end-user's workflow to provide *broader picture* of a person's overall health

- Support efforts to move healthcare in the District from reactive to *proactive*

FUTURE DC HEALTHCARE

Long-term Objectives for Care Delivery Transformation

Leverage new capabilities and competencies in person-centered care delivery to implement a broader structure supported by payment reforms and capacity building benefiting the larger District population

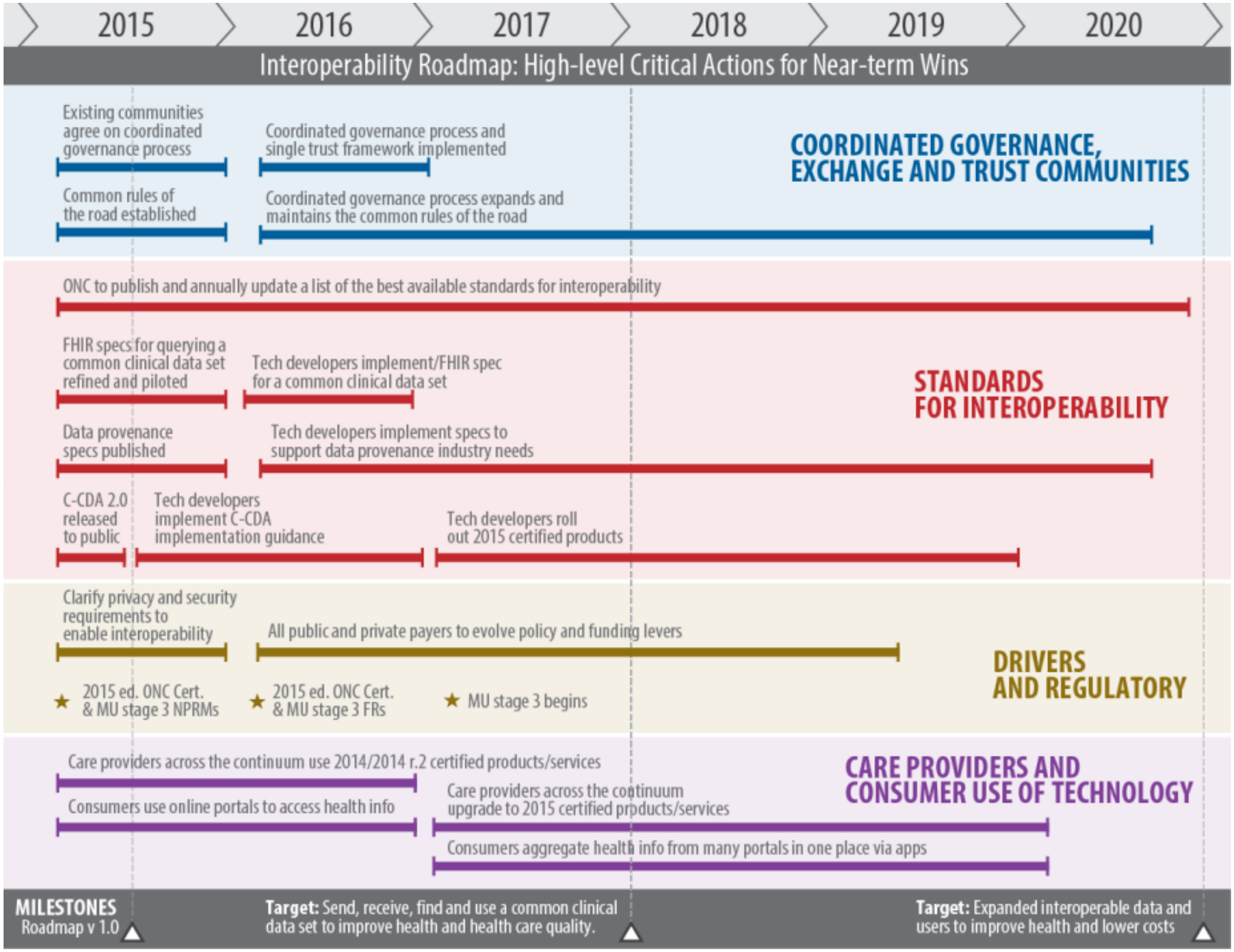
Payment	Linkages	HIT	Workforce	Quality
Align payments with value-based care goals, moving towards a risk-based model encouraging care coordination and health promotion	Use HH2 to expand the breadth and depth of community linkages and form a larger-scale support network	Expand use of care profiles, quality dashboards, and other HIT tools to better manage population health and inform care decisions	Build existing staff capacity and leverage non-clinical providers, such as Community Health Workers, to improve and maintain resident health	Expand quality measurement to capture more data on effectiveness and inform care processes, payment systems, and population health

DC TRANSFORMATION ROAD MAP

***NOTE*: Illustrative example from SIM PMWG. For discussion purposes only.**

	2017	2018	2019	2020	2021
Key Activities	• Baseline year	Year 1 of P4P payments	Menu of Payment Options (P4P, APMs)		
Base Payment	Enhanced FFS		• Enhanced FFS; or • APM (e.g. Shared Savings; Full-Risk)		
Supplemental Payment(s)	• Care Coordination Payments (HH1, HH2, EPD, DD, MCO) • P4P (e.g. bonuses and/or penalties related to readmission rates, preventable IP/ED use, hospital acquired conditions) • Other (e.g. partnership with Hospital ACO)				
Capacity Building	• Health Information Exchange • Health Home 1 and 2 (e.g. flexible PMPM dollars) • Accountable Health Communities (e.g. screening/referral resource) • Lump Sum Payment for APM/Capacity Building (see Medicare)				
Outcomes	Set baseline for LANE, Re-admissions, and IP measures	Set reduction targets (%)	• Reset baseline • Add measures based on data/priorities	Reset baseline	Reset baseline
Non-Traditional FFS Payments	• 0% APM • 30% tied to value	• 20% APM • 50% tied to value	• 30% APM • 70% tied to value	• 50% APM • 90% tied to value	

Road Map focused on Triple Aim, reducing preventable/inappropriate utilization



Source: ONC's Shared Nationwide Interoperability Roadmap (DRAFT Version 1.0)

OBJECTIVES & MILESTONES FOR FY16-17

#	OBJECTIVE	MILESTONE
1)	✓ **Define DC's HIE environment**	❑ Achieve CMS' approval for IAPD-U ❑ Establish min. capacities/functionality standards for a DC-recognized HIE entity (e.g. interoperability; security; HISP) ❑ Publish & award competitive grants to HIE entities that meet DC standards, and have the capacity to launch initiatives approved in IAPD ❑ Document DC-recognized HIE entity standards in legislation/regulation
2)	✓ **Complete 'map' of available data, data stores and data flows in DC**	❑ Document relationship between DOH's various data stores, & where data flows to/from them ❑ Incorporate information on Behavioral Health and LTC Providers

OBJECTIVES & MILESTONES FOR FY16-17

#	OBJECTIVE	MILESTONE
3)	✓ **Determine strategy to address barriers/challenges highlighted in District Data Map**	❑ Draft a resolution Action Plan - Specific mitigation solutions incorporating input from key stakeholders that are involved/affected
4)	✓ **Select priority areas for FY18-19 IAPD**	❑ Establish a Priority Use-Case Repository - Process to review, analyze, and prioritize potential use cases
5)	✓ **Develop 5-10 year plan for HIE in District**	❑ Including the development of a long-term sustainability strategy - Moves beyond CMS 90/10 IAPD funds

FEEDBACK ON DISTRICT'S STATE HEALTH INNOVATION PLAN (SHIP)

NEXT STEPS?