

MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

Minutes for the October 2016 Meeting

Date: Thursday, October 20th, 2016
1:00 pm – 3:00 pm

Location: Grand Conference Room
South Grand Building
333 South Grand Avenue
Lansing, Michigan 48933

Commissioners Present:

Patricia Rinvelt, Co-Chair
Rod Davenport (Phone)
Karen Parker
Irita Matthews
Mark Notman, Ph.D.
Randall Ritter
Nick Smith
Orest Sowirka, DO
Jill Castiglione, RPh (Phone)
Peter Schonfeld (Phone)
Rozelle Hegeman-Dingle, RPh (Phone)
Michael Chrissos, M.D. (Phone)

Commissioners Absent:

Robert Milewski

Staff:

Meghan Vanderstelt
Kim Bachelder
Phil Kurdunowicz

Attendees:

Keith Hoffman	James Noland	Beth Jabin
Kristina Dawkins	Julie Lowry	Robin Hepfinger
Larry Wagenknecht	Deana M. Newman	Phillip Bergquist
Jason Werner	Ryan Koolen	Laura Rappleeye
Katie Commey	Tom Curtis	Sharon Kim
Zane Paksi	Brad Christensen	Philip Vigés
Anya Day	Umbrin Ateequi	Greg Forzley, M.D.
Marty Woodruff	Rick Keller	Tesla Looper
Rosalyn Beene-Harris	Helen Hill	

Minutes: The regular meeting of the Michigan Health Information Technology Commission was held on Thursday, October 20th, 2016 at the South Grand Building with 12 Commissioners participating in person or by phone.

A. Welcome and Introductions

1. Co-Chair Patricia Rinvelt called the meeting to order at 1:02 p.m.
2. Co-Chair Rinvelt asked the other commissioners to introduce themselves and to share any updates since the last time that the commission convened. The other commissioners did not have any updates to share at this time.
3. Co-Chair Rinvelt noted that she recently had attended a meeting at the University of Michigan in regards to the development of a Learning Health System collaborative. She explained further that 125 people were in attendance and that the organizers were establishing several workgroups on this issue.

B. Commission Business

1. Co-Chair Rinvelt asked the commissioners to review and consider approving the minutes from the August 2016 meeting.
 - a. Commissioner Irita Matthews made a motion to approve the minutes, and Commissioner Randy Ritter seconded the motion.
 - b. Chair Rinvelt asked if there was any objection to approving the minutes. Seeing none, she noted that the minutes had been approved at 1:07 p.m.
2. Co-Chair Rinvelt asked Ms. Meghan Vanderstelt of the Michigan Department of Health and Human Services (MDHHS) to provide an overview of the plans for 2016 Annual Report for the Health Information Technology (HIT) Commission.
 - a. Ms. Vanderstelt presented an outline of the annual report to the HIT Commission and noted that the Policy Division would be filling in the details over the next two months.
 - b. Ms. Vanderstelt also mentioned that the annual report would be organized around broad themes instead of the traditional six domains.
 - c. Ms. Vanderstelt also indicated that the HIT Commission should include a forecast of 2017 activities in the report. Co-Chair Rinvelt noted that this item could be discussed at the end of the meeting.

C. HIT/HIE Update

1. Co-Chair Rinvelt invited Ms. Vanderstelt to provide an update on new developments in the HIT field since the last commission meeting. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Ms. Vanderstelt provided an overview of the HIT Commission Dashboard.
 - a. Ms. Vanderstelt highlighted the success of the Michigan Caries Prevention Program in increasing the number of oral health screenings and referrals for children.
 - b. Ms. Vanderstelt explained that the program provides grants to dental providers to expand preventive oral health services for children.
 - c. Co-Chair Rinvelt inquired about the duration of grant funding for the program, and Ms. Anya Day of Altarum noted that funding will run through October 2017.
3. Ms. Vanderstelt also provided an update on the status of resolutions that the HIT Commission made during the August meeting.
 - a. Ms. Vanderstelt noted that the HIT Commission recommended that legislation be enacted to encourage statewide adoption and use of Electronic Prescribing Controlled Substance (EPCS), and she indicated that the Policy Division is working with the MDHHS legislative liaison on this issue.
 - b. Ms. Vanderstelt also reminded the commissioners that they had made a second resolution in regards to potential collaboration between the HIT Commission and the newly created Prescription Drug and Opioid Abuse Commission.

- i. Ms. Vanderstelt noted that she had contacted the commission coordinator at the Department of Licensing and Regulatory Affairs (LARA) on this issue.
 - ii. Co-Chair Rinvelt asked about whether the new commission's meetings would be in compliance with the Open Meeting Act, and Ms. Vanderstelt confirmed that the meetings should be open to the public.
- 4. Ms. Vanderstelt also mentioned that Michigan Health Policy Forum would be occurring in November and would be focusing on the Opioid epidemic.

D. Update on the State Innovation Model

- 1. Co-Chair Rinvelt invited Mr. Tom Curtis and Mr. Phillip Bergquist from MDHHS to provide an update on the State Innovation Model (SIM) initiative. The PowerPoint slides for this presentation will be made available on the website after the meeting.
- 2. Mr. Curtis noted that Ms. Vanderstelt would also be assisting with parts of the presentation that are related to health information technology.
- 3. Mr. Curtis highlighted two specific questions that would help frame today's discussion:
 - a. How should the statewide health information sharing infrastructure in Michigan be used to support payment reform such as the SIM initiative?
 - b. What are the HIT Commission's thoughts on the statewide use cases that are being utilized to support the different health care transformation efforts under the SIM initiative?
- 4. Mr. Curtis provided an overview of the history of the SIM initiative.
 - a. Mr. Curtis explained that MDHHS submit an initial proposal to CMMI to implement delivery system reform in Michigan.
 - b. Mr. Curtis noted that the two primary goals of SIM were (1) transitioning from fee-for-service reimbursement towards value-based payments; and (2) incorporating social determinants of health into health care service delivery.
 - c. Mr. Curtis explained that this initial proposal led to a 9-month design process in 2013, which culminated in the development of the Blueprint for Health Innovation.
 - d. Mr. Curtis explained further that Michigan received \$70 million in grant funding to implement the Blueprint.
 - e. Mr. Curtis concluded by noting that Michigan moved into the first year of implementation in August 2016.
 - f. Mr. Curtis stated that the vision of SIM is one of empowerment.
 - i. Mr. Curtis explained that the goal of SIM is to move towards a person-centered health system that is coordinating care across medical settings and community organizations to address social determinants of health and to improve health outcomes.
 - ii. Mr. Curtis explained that the rationale behind the focus on social determinants is that only 10 to 20% of health is affected by health care while most of the rest is driven by social determinants.
 - g. Mr. Curtis highlighted the five components of the SIM vision:
 - i. Patient-Centered Medical Home (PCMH) – Mr. Curtis noted that SIM sought to build upon existing practice-based care management efforts such as the Michigan Primary Care Transformation project.
 - ii. Advanced Payment Models (APM)
 - a. Mr. Curtis explained that SIM is working to align federal and Medicare payment policies and strategies, which includes Medicare Access and CHIP Reauthorization Act (MACRA).

- b. Dr. Greg Forzley of Trinity noted that the Centers for Medicare and Medicaid Services have made the definition for APMs less stringent than what was included in the original rule.
 - c. Mr. Curtis explained that MDHHS is aiming to leverage contracts with Medicaid Health Plans to align these approaches.
 - d. Mr. Curtis indicated that the SIM strategy would allow for market-based innovation in payment and clinical integration and maximize provider opportunities for Medicare incentives.
 - iii. HIT/HIE – Mr. Curtis noted that SIM would seek to Leverage a statewide foundation of HIT infrastructure and HIE use cases to enable critical information sharing that support care coordination
 - iv. Community Health Innovation Region (CHIR)
 - a. Mr. Curtis explained that SIM is trying to build upon existing community coalition efforts in the five pilot regions.
 - b. Ms. Curtis noted that the 5 pilot regions are Jackson, Livingston-Washtenaw, Genesee, Muskegon, and Grand Traverse Region.
 - v. Stakeholder Engagement, Measurement, Evaluation, and Improvement
- h. Mr. Bergquist introduced himself and noted that he would be providing additional details on the Care Delivery Transformation aspect of SIM.
 - i. Mr. Bergquist explained that the SIM Care Delivery Transformation efforts build upon the MiPCT demonstration, which was a 5-year multi-payer PCMH initiative that ends in 2016.
 - ii. Mr. Bergquist highlighted some of the strengths of Michigan’s current care delivery assets, which include primary care transformation experience, lessons from accountable care organizations, care team experience, significant gains in health coverage, and a robust HIT/HIE infrastructure.
 - iii. Mr. Bergquist noted that the focus of the SIM Care Delivery Transformation initiative would have three goals:
 - a. The PCMH initiative will support and scale current elements, which include team-based care, core HIT functions (such as having a registry or having an Electronic Health Record), advanced access, care management, and self-care support.
 - b. The PCMH initiative would also encourage the “next step” for advancement, which includes integrated treatment, risk stratification, HIT-enabled quality improvement efforts.
 - c. Finally, the PMCH initiative would test promising opportunities where they exist, which may include community-centered health focus, community linkages, and population health initiatives.
 - iv. Commissioner Matthews inquired about what metrics would be used to measure progress on scaling care delivery elements that are working.
 - a. Mr. Bergquist walked through an example of the metrics for “integrative treatment planning.”
 - b. Mr. Bergquist also noted that MDHHS and other participating payers would use payment, contractual requirements, policies, and training to help drive adoption.
 - v. Mr. Bergquist noted that the PCMH initiative would have a strong focus on leveraging HIE use cases to improve care of a massive scale. He highlighted

the Transition of Care use case as an example where providers and payers could expand clinical partnerships to improve care.

- vi. Mr. Bergquist also highlighted several opportunities for growth, which include: (1) clinical-community linkages; (2) referral decision supports; (3) patient engagement, health literacy, and social determinant perspectives; and (4) patient reported outcomes.
- vii. Mr. Bergquist provided some perspective on where the SIM Care Delivery initiative is headed from here.
 - a. Mr. Bergquist noted that the Care Delivery initiative would pick up from where MiPCT leaves off at the end of 2016: he explained that providers would either participate in the Medicare Comprehensive Primary Care Plus initiative or the SIM PCMH initiative in 2017.
 - i. Mr. Bergquist noted that MDHHS completed the application process for the 2017 PCMH initiative in September and received applications for 480 practices units and 2,300 primary care providers.
 - ii. Commissioner Mark Notman inquired about how the PCMH applicants are distributed and whether this initiative is statewide. Mr. Bergquist explained that half of the applicants are in SIM regions but that the rest are distributed around the state.
 - iii. Mr. Bergquist noted that MDHHS would notify applicants on whether they were selected to participate in October.
 - b. Mr. Bergquist also explained that Michigan would eventually transition into using a “custom option” to support the PCMH initiative, which would include implementing new APMs.
- i. Mr. Curtis returned to the podium and provided perspective on the SIM Population Health Improvement Strategy.
 - i. Mr. Curtis provided an overview of the “Health Impact Pyramid” and explained its relevance for SIM.
 - ii. Mr. Curtis explained the role of the CHIRs in weaving together the various aspects of SIM to achieve a collective impact on population health.
 - iii. Mr. Curtis highlighted key CHIR functions, which include assessing community needs, defining common priorities, adopting shared measures of success, engaging in mutually reinforcing strategies toward common priorities, implementing systems to coordinate health care, community services, and public health, and investing in population health.
 - iv. Co-Chair Rinvelt inquired about whether the CHIRs are organized by city, county, or some other configuration.
 - a. Mr. Curtis explained that the 5 CHIR regions are aligned with the 5 PCMH regions, which are: Muskegon, Grand Traverse, Washtenaw/Livingston, Genesee, and Jackson.
 - b. Mr. Curtis also highlighted the responsibilities of the neutral convener of each CHIR, which functions as the designated backbone organization that brings local stakeholders together.
 - v. Mr. Curtis elaborated on the role of the CHIRs in SIM, which includes engaging communities in health system transformation, linking delivery of

- clinical and community services, and assessing social needs that are important in these communities.
- vi. Mr. Curtis also highlighted the role of the CHIRs in convening health care stakeholders across the system.
 - a. Mr. Curtis noted that CHIRs are required to convene a core set of stakeholders which includes local health departments, Accountable Systems of Care, Medicaid Health Plans, Federally Qualified Health Centers, Community Mental Health Agencies, payers, and community members.
 - b. Mr. Curtis noted that CHIRs may include other stakeholders such as employers and purchasers, community organizations, human service providers, philanthropy, local governments, community and economic development partners, community safety and corrections, educational institutions, housing agencies, and others.
 - vii. Mr. Curtis explained the role of Accountable Systems of Care (ASC) in operationalizing transformation within the CHIR, which includes supporting development of clinical-community linkage initiative, supporting development of plan for analyzing clinical-community linkage information, and supporting incorporation of analysis into community-decision making.
 - a. Commissioner Nick Smith inquired about what the incentive is for providers and payers to share systems and information.
 - b. Mr. Curtis noted that payers and providers have realized the importance of participating in payment reform and population in order to succeed in the changing business environment.
 - c. Commissioner Smith mentioned that certain providers and payers are further down this track than others and inquired about how to get them to play nicely with each other.
 - d. Mr. Curtis highlighted the potential role of CHIRs in brokering discussions about roles and responsibilities.
 - viii. Commissioner Matthews noted the importance of achieving an agreement on data standards for collaborative models. She also asked about whether the federal government is funding similar models in other states.
 - a. Mr. Curtis stated that Washington State has a similar model but that Washington is the closest to Michigan.
 - b. Commissioner Matthews wondered whether we could learn lessons from other states on this issue.
 - ix. Commissioner Notman voiced concerns about duplicating efforts across multiple CHIRs and inquired about whether there was a way to develop centralized systems and statewide standards.
 - a. Ms. Vanderstelt noted that MDHHS is currently learning about what differences exist between regions.
 - b. Ms. Vanderstelt explained that the end goal is achieving some level of standardization but noted that the process will be incremental.
 - x. Mr. Curtis concluded by explaining that the goal of the CHIR test is determining the unit cost of CHIRs as well as the cost of collaborative learning and other supports.
 - j. Mr. Bergquist took over the presentation from Mr. Curtis and noted that he would be providing an overview of the payment reform strategy.

- i. Mr. Bergquist noted that the payment reform strategy had changed substantially since the Blueprint due to changes and advancements in the regulatory environment.
- ii. Mr. Bergquist introduced the Health Care Payment Learning and Action Network Framework and highlighted its importance in guiding SIM payment reform. He walked through the individual categories of the framework.
 - a. Category 1 – Fee For Service: No Link to Quality and Value
 - b. Category 2 – Fee for Service: Link to Quality and Value
 - c. Category 3 – APMs Built on FFS Architecture
 - d. Category 4 – Population-Based Payment
- iii. Mr. Bergquist described the impact of the MACRA legislation and Comprehensive Primary Care Plus (CPC+) initiative on changing the payment reform discussion.
 - a. Mr. Bergquist noted that the Blueprint pilot model for ASCs would not meet the definition of APM under MACRA.
 - b. Mr. Bergquist also noted that the ASC pilot would involve a limited number of providers at high resource cost, which would not necessarily be offset by broad-based APM adoption.
 - c. Mr. Bergquist also highlighted the role of the CPC+ announcement in altering Michigan’s approach on payment reform for PCMHs.
- iv. Mr. Bergquist outlined the SIM vision for payment reform.
 - a. Mr. Bergquist clarified that the Michigan Medicaid Program will not be defining every APM.
 - i. Mr. Bergquist elaborated further that the Medicaid program will recognize and encourage work beyond MDHHS programs.
 - ii. Mr. Bergquist also indicated that Medicaid Health Plans will develop their own APMs with providers and explained that Medicaid will define a couple of APMs that are critical to the vision of the Blueprint but let others grow around it.
 - b. Mr. Bergquist highlighted the transition of the SIM payment reform strategy from development of ASCs towards broad-based adoption of APMs.
 - c. Mr. Bergquist noted that ASCs in SIM regions will be eligible for SIM funding.
 - d. Mr. Bergquist explained that ASC support will be focused on work related to priorities and goals of the CHIRs.
 - e. Mr. Bergquist also indicated that developing clinical-community linkages will be required activity.
 - f. Mr. Bergquist described the strategy for accelerating broad-based adoption of APMs on a statewide basis.
 - i. Mr. Bergquist noted that APM adoption in the Medicaid program will be encouraged through contracts with Medicaid Health Plans.
 - ii. Mr. Bergquist also explained that APM adoption by other payers will be encouraged through collaborative discussions and partnerships.

- iii. Mr. Bergquist noted that MDHHS would start to collect baseline information on APM adoption and establish goals for 2017, 2018, and 2019. He explained that MDHHS would progressively increase percentage of payment in APMs.
- k. Ms. Vanderstelt took over the presentation and noted that she would provide some perspective on the plan for supporting the adoption of HIT and statewide use cases.
 - i. Ms. Vanderstelt indicated that one of the leading principles for the HIT/HIE strategy is leveraging existing components throughout the SIM initiative.
 - ii. Ms. Vanderstelt highlighted the key objectives in the SIM Operational Plan.
 - a. Performance Metrics and Reporting – Ms. Vanderstelt noted that the HIT/HIE infrastructure would be leveraged to provide data aggregation and reporting capabilities needed to support SIM performance reporting and evaluation of provider performance.
 - b. Care Coordination Technology – Ms. Vanderstelt explained that SIM will facilitate access to information which supports care coordination activities within the model test.
 - c. Population Health Technology – Ms. Vanderstelt indicated that SIM will explore Population Health technology solutions that will enable community data sharing and track cross-care delivery approaches.
 - d. Relationship Attribution Management Platform
 - i. Ms. Vanderstelt explained that MDHHS and its partners are developing the infrastructure to enable a consistent shared process for communicating and tracking affiliations and linkages among SIM stakeholders.
 - ii. Ms. Vanderstelt noted that the Active Care Relationship Service, Health Provider Directory, and Common Key Service are the three required core use cases for SIM participants.
 - iii. Ms. Vanderstelt outlined the schedule for onboarding participating PCMH practices with key statewide use cases.
 - iv. Ms. Vanderstelt also described the recent activities at the Medicaid Payer Qualified Organization Day where Medicaid Health Plans were onboarded for participation in the SIM initiative. She explained that the onboarding process included technical and legal components as well as discussion of payment reform requirements.
 - v. Ms. Vanderstelt also noted that MDHHS is working on implementing various strategies to align quality measure reporting, monitor PCMH and CHIR performance, and aggregate data for further analysis and evaluation.
 - vi. Commissioner Ritter inquired about whether the initial \$70 million would be the only funding available to support implementation across all four years.
 - a. Ms. Vanderstelt replied that many of the key programs and components of infrastructure are already in place.
 - b. Ms. Vanderstelt also acknowledged that Michigan has a very ambitious SIM plan for four years.
 - vii. Co-Chair Rinvelt asked for a breakdown of how the \$70 million would be spent during the initiative.
 - a. Mr. Curtis noted that the bulk of grant funding would be used to support technology development and staffing for the project.

- b. Mr. Curtis noted that an additional \$20 million would be spent on services for individuals who use Medicaid services.
 - viii. Commissioner Matthews inquired about how MDHHS and SIM participants would collect data to monitor and track progress on addressing social determinants of health.
 - a. Ms. Vanderstelt noted that many measures had been evaluated and that the measurement strategy would be developed as the operational plans in the individual regions are constructed.
 - b. Ms. Vanderstelt also highlighted the role in the clinical-community linkage in measuring these elements.
- I. Ms. Vanderstelt also provided some perspective on the process for engaging stakeholders in the development and implementation of the SIM initiative as well as the process for evaluating the results of the initiative.
 - i. Ms. Vanderstelt explained that MDHHS would be convening a series of committees to advise MDHHS on implementation of this initiative.
 - ii. Ms. Vanderstelt stated that the Healthcare Payment and Delivery Committee would be launched in late November.
 - iii. Ms. Vanderstelt noted that additional committees would be launched on the following topics: Clinical Care Delivery, HIT-HIE, Payment Reform, and Non-Clinical Care.
 - iv. Ms. Vanderstelt elaborated on approach for evaluating the SIM initiative.
 - a. Ms. Vanderstelt noted that the evaluation would focus on PCMH and CHIR components and emphasizing clinical-community linkage adoption and effectiveness.
 - b. Ms. Vanderstelt explained that MDHHS is developing a Request For Proposals (RPF) for release and selection before the end of year.
- m. Co-Chair Rinvelt emphasized the ability of MDHHS to build upon Michigan’s current HIT-HIE infrastructure and other health policy initiatives during implementation.
 - i. Ms. Vanderstelt noted that SIM offers a great opportunity to move beyond building the HIT-HIE infrastructure and towards using the infrastructure to further policy and programmatic objectives.
 - ii. Commissioner Matthews noted that stakeholder involvement will help with inform the question of how to leverage the infrastructure to the great extent during the initiative.

E. HIT Commission Next Steps

1. Ms. Vanderstelt noted that the next meetings for the HIT Commission would be held in February, May, September, and November 2017. She encouraged the commissioners to check their schedules for these dates.
2. Ms. Vanderstelt also walked through the process for developing and finalizing the 2016 Annual Report. She noted that the Policy Division was aiming to develop a first draft for HIT Commission review within the next month with the goal of having a final draft ready for approval and submission in February 2017.
3. Ms. Vanderstelt also displayed a list of potential topics for 2017 HIT Commission meetings, which would be incorporated into the 2017 forecast in the annual report.

F. Public Comment

1. Co-Chair Rinvelt invited the attendees to introduce themselves and offer public comment.

2. Ms. Helen Hill of the Healthcare Information and Management Systems Society (HIMSS) encouraged attendees to sign up for the HIMSS conference in February in Orlando. Ms. Hill noted that HIMSS is doing a follow-up session at the conference with the Office of the National Coordinator on guidance for connecting communities for public health.
3. Other attendees introduced themselves.

G. Adjourn

1. Co-Chair Rinvelt asked if there was a motion to adjourn the meeting.
2. Multiple commissioners supported a motion to adjourn the meeting, and multiple commissioners seconded the motion.
3. Co-Chair Rinvelt asked if there was any objection to adjourning the meeting. Seeing none, she noted that the meeting was adjourned at 3:02 pm.