

# HIE Work Group Meeting Agenda

4-09-14

***VT Health Care Innovation Project  
HIE Work Group Meeting Agenda***

**Wednesday, April 9, 2014; 9:00-11:30am  
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT  
Call-In Number: 1-877-273-4202; Passcode 2252454**

<b>Item #</b>	<b>Time Frame</b>	<b>Topic</b>	<b>Presenter</b>	<b>Relevant Attachments</b>
1	9:00-9:05	Welcome and Introductions	Brian Otley and Simone Rueschemeyer	
2	9:05-9:10	Review and Acceptance of February 26 <sup>th</sup> Meeting Minutes	Brian Otley and Simone Rueschemeyer	Attachment 2: HIE Work Group Minutes 2.26.2014
3	9:10-9:30	ACO and ACTT Proposal: Updates	Richard Slusky and Steve Maier	
4	9:30-10:10	WG Charge: What we have done and what have left to do ( Work plan review vs. approved projects)	Brian Otley and Simone Rueschemeyer	Attachment 4a: HIE Work Plan Attachment 4b: HIE 3 Month Agenda
5	10:10-10:40	Telemedicine/Telehealth/Telemonitoring: Intro  - What do people know about these topics? What do they want to know?	Brian Otley and Simone Rueschemeyer	Attachment 5: DFR- Telemedicine Provided Outside A Health Facility
6	10:40-10:50	Grant Program 'referrals' discussion	Brian Otley and Simone Rueschemeyer	
7	10:50-11:20	VITL Presentation: Data Warehousing Roadmap	Michael Gagnon	Attachment 7: Building A State-Wide Data Warehouse

8	11:20-11:25	Public Comment	Brian Otley and Simone Rueschemeyer	
9	11:25-11:30	Next Steps, Wrap-Up and Future Meeting Schedule	Brian Otley and Simone Rueschemeyer	

# Attachment 2 - HIE Meeting Minutes

## 2-26-14



## ***VT Health Care Innovation Project HIE Work Group Meeting Minutes***

**Date of meeting: February 26, 2014      Call in: 877-273-4202 Passcode: 2252454**

**Attendees: Simone Rueschemeyer, Brian Otley, Co-Chairs; Paul Harrington, Vermont Medical Society; Mike Del Trecco, VT Assn of Hospitals; Lou McLaren, MVP; Eileen Underwood, VDH; Larry Sandage, Jen Egelhoff, Erin Flynn, Alicia Cooper, DVHA; Brendan Hogan, Bailit Health Purchasing; Julie Wasserman, AHS; Tela Torrey, Marybeth McCaffrey, Nancy Marinelli, and Jen Woodward, DAIL; Georgia Maheras, AOA; Richard Slusky, Annie Paumgarten, Spenser Wepler, GMCB; Karl Finison, Onpoint Health Data; David Martini, DFR; Joyce Gallimore, CHAC; Bob Thorn, Counseling Services of Addison; Sandy Rouse, Central CT Home Health and Hospice; Jack Donnelly, Community Health Center of Burlington; Sean Uiterwyk, MD; Kate Simmons, Bi-State; Steve Maier, AHS; Beth Riley; Justin Bow; Nelson LaMothe, George Sales, Jessica Mendizabal, Project Management Team.**

<b>Agenda Item</b>	<b>Discussion</b>	<b>Next Steps</b>
<b>1 Welcome and Introduction</b>	Simone Rueschemeyer called the meeting to order at 9:03 am.	
<b>2 Review and Acceptance of Feb. 5<sup>th</sup> &amp; 11<sup>th</sup> minutes</b>	Simone Rueschemeyer opened the floor for comments on the minutes from Feb. 11 and Feb. 5 <sup>th</sup> meetings. Marybeth McCaffrey suggested to change the language in the Feb. 5 <sup>th</sup> minutes from “Full Service Provider Proposal” to the “ACTT proposal” and noted that she did attend the Feb. 11 <sup>th</sup> meeting. Nancy Marinelli moved to accept the minutes pending changes, Eileen Underwood seconded the motion, all were in favor. Georgia welcomed Jessica Mendizabal, the new Project Coordinator for the UMass Medical School team. Marybeth McCaffrey welcomed Jennifer Woodward who will be working at DAIL.	
<b>3 Staff Housekeeping</b>	Brian Otley acknowledged the fact that there will be conflicts of interests in many of the activities that the group does, and to use best judgment when conducting the business of the work group. He also reminded the group of the Conflict of Interest statement and to please sign and become familiar with the document.	

Agenda Item	Discussion	Next Steps
<p><b>4 Update: Population-Based Collaborative HIE Proposal</b></p>	<p>The Pan ACO proposal was recommended to the Steering Committee and the Core Team and approved. It was submitted to CMMI and will take 30 to 60 days for the final execution. Lou McLaren questioned the portion of funding from the total grant that is being set aside for proposals and if HIE was the only committee with funds and proposals. Georgia Maheras discussed that several workgroups have funding, the HIE work group has 9.3 mil which is the largest allocated to any work group due to the cost of IT projects. The Core Team has the ability to shift funding around if deemed necessary. Intent with HIE is done in collaborative manner. Funds must be spent by Sept. 30, 2016, or will be returned to CMMI. Georgia noted it is better to frontload the funds for HIE and HIT because those project can take longer. The HIE work group can make the best informed recommendations and Georgia will work on the timelines. Sandy Rouse asked for the entire budget and Georgia directed the group to the SIM website as well as Project Reporter (a project management tool with archive files from all work groups) to view the Core Team minutes.</p>	
<p><b>5 Status Report: ACTT Proposal</b></p>	<p>Brian Otley brought attention to ACTT proposal and Q&amp;A for proposal. Open dialogue and feedback from group: Jennifer Eglehoff asked about the Universal Transfer Form (UTF) and voiced concerns about the low tech options considered and questioned if the continuity of care document will tie into the form.</p> <p>Marybeth McCaffrey gave the status of the project: the UTF moved from conceptual to early planning phase. She worked with Mike Gagnon from VITL on the approach. The Office of the National Coordinator (ONC) and CMMI also made recommendations. There are two phases; planning/design and implementation. The proposal has also been shared with Home Health, Nursing Home &amp; Res Care, and ABRC Partners.</p> <p>The planning phase defines what is currently working well (such as VT has the lowest hospital re-admission rates in the country) and acknowledges the system still has room for improvement. Marybeth McCaffrey worked with a group in Massachusetts, which developed two versions of the form to facilitate providers with and without EMRs: LAND, a high-tech version, and SEE, a low-tech web based interface. Family caregivers recognize that we need solutions to help with non-medical care providers as well. Next steps include describing the current workflow and devising a simple solution to pilot with real people and identify what works and what needs to change. This is why the group would start with a low tech tool, and move onto something more complicated</p>	<p><b>Georgia will confirm provider incentive funds as an allowable cost; email budget spreadsheets to work group.</b></p>

Agenda Item	Discussion	Next Steps
	<p>using structured data from EMRs and need providers to define that. Brian offered that this way you can clearly see a path of development and when you enter into automation there is less trial and error. He questioned if this approach is reflected in the cost estimates and timeline, which it is. The funding proposed is to cover phase one planning. Funding for implementation will most likely need to be separate.</p> <p>Sean Uiterwyk reached out to three people in Massachusetts with different roles, although he did not speak with anyone in NJ, but other states recommended by ONC and CMMI, Home Health agencies etc. He discussed the OASIS, continuity of care and ADT forms. The UTF would not replace these forms, but if there is information in the OASIS form that might be useful, the UTF may pull information from it. Nancy Marinelli noted the OASIS form is required for assessment and transition of care, but the UTF form will be for admission, discharges and transfers. Sandy Rouse mentioned the plan of care document that physicians have to sign, which is more of a claim format, required by CMS and can be tedious to read.</p> <p>Marybeth McCaffrey noted the network of Long Term Care Services (LTSS) is looking at other states taking the OASIS tool and extracting data for other uses, which is funded by CMS. Bob Thorn questioned if Brian was looking for a motion of support to send the funding up stream. A discussion about funding followed.</p> <p>The funding for the entire proposal is \$2.5 mil, for 3 separate but related projects. \$1 mil would be for a one-time infrastructure and the other funding would be for data quality so we can use the data to report to ACO and other agencies. The state is supporting whatever it can to have providers in the systems run the program. DAIL will work to figure out what the specific needs are. Brendan Hogan offered that the 3<sup>rd</sup> project in the proposal involves narrowing a list of quality measures for IT providers in Medicaid ACO and Long Term Care. Planning work is being done around developing a process to see if there are IT needs to implement. Work is also being done around gap analysis for providers who have not had it before which includes aging, residential care homes, and day centers etc. Plans and a budget will be developed and options for these providers will likely be low tech since they may not have access to EMR but would be able to have access to web.</p> <p>Brian Otley questioned the origin of the hourly and cost estimates in the proposal. Marybeth</p>	

Agenda Item	Discussion	Next Steps
	<p>noted that she worked with Massachusetts groups to assess what was needed in order to convene provider groups. The budget also includes: a few hours per week of project management for Marybeth’s time; support for Jen Woodward; a few hours a week for VITL at \$250/hr for 16 weeks; consultant fees to engage the team and facilitate provider information and draft the end product in a detailed project charter; and hourly incentive funds for providers. Georgia Maheras noted that CMMI has not clearly defined provider incentive payments as an allowed spending area and she will confirm this.</p> <p>Mike DelTrecco expressed budget concerns regarding the origin of funds (state vs. federal), the consultant rate of \$250/hr., and questioned how this is similar to the Pan ACO work recently approved. Georgia explained the work falls under the HIE work groups’ purview, for which 6.3 mil remains in the budget. Mike questioned whether there were state/federal matching funds to pay for these high consultant costs. Lou McLaren questioned if the costs were understated and the budget needed to be revisited. A discussion about consultant costs followed with group members noting the range of consultant costs in the past, suggesting \$250 is an average rate. Brian suggested a fixed bid is better than an hourly rate and if there is any way to lower the rate. Marybeth McCaffrey noted the tight timeframe as a potential reason for high costs, has vetted the costs and is confident they can complete project charter responsive to risks. Brian recommended being aggressive in negotiations. Marybeth McCaffrey clarified that the staff project management time for Jen Woodward is related to support and coordination rather than technical project management, and this is not included in the proposal.</p> <p>The State currently has a standing rate with VITL at \$200/hr but Steve Maier was not able to confirm this. Georgia confirmed CMMI prefers contracts to be deliverable project based, not hourly rate based but agreed \$200/hr is within ballpark. Brian Otley asked if the consultant can do a fixed bid to which Marybeth McCaffrey responded that she would like a recommendation from the work group that this project is worthwhile before pursuing further.</p> <p>Paul Harrington noted that the ACTT is partnership consortium of designated and specialized agencies, and would like to identify who the fiscal agent will be. The group discussed and concluded DVHA should be the fiscal agent and monitor the contract. The recipient for the 1<sup>st</sup> project would likely be a behavior health organization. Georgia noted that most of the SIM contracts are going through DVHA, though DAIL might monitor this particular contract. All State</p>	

Agenda Item	Discussion	Next Steps
	<p>agencies are subject to OMB 133 single audit, as well as sub-recipients.</p> <p>The group proceeded to discuss the following concerns at length:</p> <ol style="list-style-type: none"> <li>1. Duplication of work under the Pan ACO and ACTT proposals. Simone Rueschemeyer noted a lot of work went into looking at the proposals making sure there is not duplication- work being done by ACOs and analytics won't work with LTSS and the work needs to go beyond primary care. The Core Team has approved the ACO VITL proposal it is going to CMMI for review. Brendan stated that this ties into gap analysis and is different in each proposal but they are complimentary and working on getting baseline information.</li> <li>2. Whether the State is maximizing the use of funding by using SIM grant money for these projects, and if it should explore the 90-10 matching arrangement for Medicaid projects through CMS. Steve Maier is trying to coordinate with the feds about this topic on what is allowable and whether these projects would be eligible. The group raised questions around what will be most advantageous for the State.</li> <li>3. Does the group have enough information to make a recommendation to the steering committee? Brian offered that the proposal has great potential but questioned if the group was comfortable making a recommendation without having all of the information.</li> </ol> <p>Before the April 16<sup>th</sup> Steering Committee meeting Marybeth McCaffrey agreed to gather more information for the group. The Core Team would be able to consider a recommendation then on April 21. The HIE meets again on April 9. Paul Harrington questioned if the proposal is divisible and expressed support for the 200k now, and to wait for additional information to recommend the remaining parts of the project.</p> <p>Group members expressed support for moving forward given the importance of the work and identified the additional information needed in order to make a recommendation including that the final contractor is accountable and has ownership over the project. The work group acknowledged that ACTT is the group that will do this work. DVHA will give sub grants to other entities, Bailit Health Network will receive funding for bringing the provider group together and VITL will receive funding for the IT portion. Marybeth</p>	

Agenda Item	Discussion	Next Steps
	<p>McCaffrey will look at the pre-approved contractor list to speed up process. Brendan Hogan noted the contract would not go to a newly created entity because LTC providers are all different. Mike DeTecco also recommended creating a flow chart of how both the ACO and ACTT projects relate and eliminate duplication.</p> <p>After further explanation of the points discussed above, Paul Harrington motioned for conditional approval of the ACTT partnership proposal with following understanding:</p> <ol style="list-style-type: none"> <li>1. The grant recipient is DVHA working with partners on the proposal;</li> <li>2. DVHA analyzes the benefits of using Medicaid matching funds for some of the activities in the proposal;</li> <li>3. The HIE work group and Steering Committee be given analysis on how the ACO proposal integrates and is complimentary.</li> </ol> <p>The motion was seconded by Joyce Gallimore, all were in favor. Simone Rueschemeyer abstained. Georgia mentioned that it will be difficult to recommend to steering committee by March 5<sup>th</sup>, and may discuss via email due to work absences from key people.</p>	
<p><b>6 Review Work Plan Goals 4-6</b></p>	<p>Simone Rueschemeyer reviewed the work plan goals #4-#6.</p> <p><i>#4- Align and integrate Vermont’s electronic health information systems, both public and private, to enable the comprehensive and secure exchange of personal health and human services records.</i> Simone Rueschemeyer opened up to the group for comment and suggestions, noting some of the work already being proposed is targeting a lot of the objectives. Paul Harrington noted prior meetings’ advocacy for integration and important activities dealing with the opioid epidemic which should be added to this list as well as trying to achieve a single login in for the different depositories. Sean Uiterwyk noted this was discussed at the previous meeting. Jennifer Egelhoff discussed the PBM vendors overall plan to develop a medication management program, focusing on electronic prior authorizations. Larry Sandage acknowledged this work is included under MMIS and will elaborate in the next version.</p> <p><i>#5 Improve the ability of consumers to engage in their own health and health care through the use of technology.</i> Larry Sandage stated that overall this goal is primarily concerned with HIE</p>	

Agenda Item	Discussion	Next Steps
	<p>populations. Brendan Hogan discussed certain subsets of patients, and patient supports such as with the elderly and disabled. Larry Sandage noted patient portals which are not yet being worked on but the discussion is happening. Sean Uiterwyk noted using patient portals already, Marybeth McCaffrey stated that for transfer form people would like to have it there, it would be broad. Simone Rueschemeyer acknowledged there needs to be further discussion around this topic. Kate Simmons suggested adding home health monitoring to the list of innovative programs. Simone wants to discuss tele-health at the next meeting and posed to the group if they would like presentations on tele-health or just a general discussion? Lou McLaren stated that this is already being done by payers and there needs to be some level of data collection and data share to understand what is already required and being collected. Marybeth McCaffrey recommended looking at webinars as preparation to have a more informed discussion.</p> <p><i>#7 To participate in the development of policies, rules, procedures, and legislation, when necessary, in support of improved statewide HIE standards HER use. Simone Rueschemeyer noted work is already being done on a consent policy, and looking into what other states are doing. Paul mentioned part 4 is being done by the ACTT work group. Larry Sandage asked for additional comments, no comments offered. Simone will make adjustments to goals and objectives and further investigate telemedicine.</i></p>	
<p><b>7 Report on Grant Applications</b></p>	<p>Georgia Maheras explained that the Core Team received many submissions which are confidential and she could not discuss total dollar amount. She noted that if there are applications related to HIE those may be given to the workgroup to consider instead. The Core Team expects to announce the grant awards on March 25. There will be another grant application round near end of spring and into summer. Once applications are approved the HIE work group may see those proposals at the April 9<sup>th</sup> meeting. Proposals being sent to the HIE work group for consideration come from the HIE budget and will be vetted within the work group process. Hypothetically, the funding will come out of the work group budget, then it would still go to Steering and Core Team for final approval. Paul noted that the HIE group has already recommended 5.5 mil and has budget of 9.3 mil. Both proposals already received will need more funding, potentially, larger sums and the group will need to prioritize future activities.</p> <p>Larry Sandage noted that from programmatic point of view the group needs to understand the sustainability of projects going forward and how they will attain funding when federal dollars run</p>	

Agenda Item	Discussion	Next Steps
	out. Georgia acknowledged that the State IT needs far out-weigh the available funding. Simone Rueschemeyer noted this is only a start to funding for these projects.	
<b>8 Public Comment</b>	Marybeth McCaffrey observed that the processes the group is developing seems to be getting clearer and appreciates the thoughtfulness of the discussions. No other public comments were presented.	
<b>9 Next Steps, Wrap-Up and Future Meeting Schedule</b>	Next meeting April 9, 2014 9-11:30 am, Hurricane Lane, Williston. Materials will be given in advance. There was no other business and the meeting was adjourned.	

# Attachment 4a - HIE Work Plan

## Work Plan for VHCIP/HIE Work Group – UPDATED – 4/9/2014

**Overall VHCIP Project Strategy:** Vermont’s strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance. We are implementing this strategy in a comprehensive manner – across acute and long-term care providers, across mental and physical health and across public and private payers. Our project is aimed at assuring a health care system that is affordable and sustainable through coordinated efforts to lower overall costs and improve health and health care for Vermonters, throughout their lives (excerpt from VHCIP Operational Plan).

**Overall Goal of VHCIP/ HIE Projects:** To ensure the availability of **clinical** health data or information necessary to support the care delivery and payment models being tested in the VHCIP Project, including those associated with the Shared Savings/ ACO, Episode of Care, Pay-for-Performance, and Care Delivery models.

**How to Use this Work Plan:** This plan is intended to provide focus to the VHCIP/HIE Work Group by beginning with the broad, conceptual State of Vermont HIE goals. These goals are not necessarily the goals of the VHCIP Grant, though many do align. Working from left to right, this plan lays out HIE Goals, VHCIP/HIE Objectives, and then Suggested Supporting Activities. The Plan starts out broadly and moves to more specific detail, flowing from left to right. In later versions, it will include information regarding Measures of Success and a schedule, among other information.

HIE Goals	VHCIP/HIE Work Group Objectives	Suggested Supporting Activities	Accommodated by Project
To improve the utilization, functionality & interoperability of the source systems providing data for the exchange of health information	<ul style="list-style-type: none"> <li>Explore and, as appropriate, invest in technologies that improve the integration of health care services and enhanced communication among providers</li> <li>Identify core requirements for source systems to meet SOV HIE standards</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate EHR capabilities and interoperability</li> <li>Evaluate and recommend technologies (such as APIs and SSOs) that would improve the integration of disparate EHR systems.</li> <li>Identify vendors that meet SOV HIE standards.</li> <li>Develop recommendations to improve the SOV HIE infrastructure through procurements such as:               <ul style="list-style-type: none"> <li>Integration Repository</li> <li>Provider Portal (Single Sign-on)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Population-Based Health Information Exchange Collaboration</li> <li>Advancing Care Through Technology</li> </ul>
To improve data quality and accuracy for the exchange of health information	<ul style="list-style-type: none"> <li>Increase resources to facilitate improved EHR utilization at the provider practice level</li> <li>Identify and resolve gaps in EHR usage, lab result, ADT, and immunization reporting, and transmission of useable CCDs.</li> <li>Improve consistency in data gathering and entry</li> <li>Support the Development of advanced analytics and reporting systems as needed</li> </ul>	<ul style="list-style-type: none"> <li>Expand health information and HIT facilitators (such as VITL e-Health Specialists) to provide direct assistance, data quality workflow recommendations, and technical assistance to providers</li> <li>Evaluate and implement solutions to bridge gaps in CCD/ADT/VXU and other message standards consistent with identified needs</li> <li>Facilitate the implementation of workflow solutions necessary to clean and normalize data to improve clinical services and practice efficiency</li> <li>Improve or develop analytic capabilities such as:               <ul style="list-style-type: none"> <li>Predictive modeling</li> <li>Reporting portals and dashboards</li> </ul> </li> <li>Suggest criteria to be incorporated into RFPs for HIE grants or contracts such as the Clinical Registry, VITL Grant, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Population-Based Health Information Exchange Collaboration</li> <li>Advancing Care Through Technology</li> </ul>
To improve the ability of all health and human services professionals to exchange health information	<ul style="list-style-type: none"> <li>Facilitate connectivity to the HIE for ACOs and their participating providers and affiliates</li> <li>Standardize technical connectivity requirements to participating provider entities</li> <li>Facilitate EHR adoption to current non-adopters</li> <li>Facilitate connectivity to providers who are not yet connected to the HIE regardless of ACO participation</li> </ul>	<ul style="list-style-type: none"> <li>Develop and implement strategic recommendations for identification and transmission of EHR information including the data elements for ACO measures</li> <li>Identify and develop data requirements to meet critical health and human services data measures</li> <li>Develop strategic and operational recommendations and technical assistance necessary to connect all health care and community based providers to the HIE</li> <li>Identify barriers and develop strategies for accommodating privacy and security requirements</li> </ul>	<ul style="list-style-type: none"> <li>Population-Based Health Information Exchange Collaboration</li> <li>Advancing Care Through Technology</li> </ul>
To align and integrate Vermont’s electronic health	<ul style="list-style-type: none"> <li>Expand Connectivity to other state data and technology resources</li> </ul>	<ul style="list-style-type: none"> <li>Develop recommendations for HIE connectivity to:               <ul style="list-style-type: none"> <li>Public Health</li> <li>DMH and DAIL Data Systems</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Advancing Care Through Technology</li> </ul>

HIE Goals	VHCIP/HIE Work Group Objectives	Suggested Supporting Activities	Accommodated by Project
<p>information systems, both public and private, to enable the comprehensive and secure exchange of personal health and human services records</p>		<ul style="list-style-type: none"> <li>○ Survey/Assessment Data</li> <li>○ VHCURES</li> <li>○ MMIS</li> <li>○ Eligibility Systems</li> <li>○ Social Determinant Systems</li> <li>○ Labor, employment and economic data</li> <li>○ Analytics vendors</li> <li>○ Others</li> </ul>	
<p>To improve the ability of consumers to engage in their own health and health care through the use of technology</p>	<ul style="list-style-type: none"> <li>● Identify, review, and recommend programs and technology options for providing health information to consumers</li> </ul>	<ul style="list-style-type: none"> <li>● Research patient portal use and effectiveness</li> <li>● Identify and review innovative programs or technologies, such as mobile apps, patient portals, etc.</li> <li>● Make strategic recommendations for broad statewide advancement in providing health information directly to consumers</li> <li>● Provide information on privacy and security</li> </ul>	
<p>To participate in the development of policies, rules, procedures, and legislation, when necessary, in support of improved statewide HIE standards and EHR use</p>	<ul style="list-style-type: none"> <li>● Create an HIE governance structure to ensure the development of common HIE strategies, coordination of programs, and efficient use of resources</li> <li>● Review existing policies/legislation and the challenges they currently present</li> <li>● Recommend and support new policies, rules, regulations, laws to help the state's HIE be more effective and efficient</li> <li>● Provide input into the Vermont Health Information Strategic Plan (VHISP)</li> </ul>	<ul style="list-style-type: none"> <li>● Review and comment on any proposed revisions to the Consent Policy</li> <li>● Review and comment on the VHISP, including suggested revisions to the HIT Plan</li> <li>● Develop recommendations to support the exchange of sensitive health information, including especially from federally regulated substance abuse treatment (42 CFR Part 2) programs</li> </ul>	

Attachment 4b - HIE Work  
Group Three Month Agenda  
4-09-14

***VT Health Care Innovation Project  
HIE Work Group  
3 Month Agenda 4-09-14***

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**May:**

1. Telemedicine:
  - a. Criteria development
  - b. Solicitations
2. Grant program: analytics work
3. Referrals from QPM
4. Evaluation

**June:**

1. Grant program: Recommendations to Steering
2. Telemedicine proposals
3. Referrals from QPM
4. Overview of Vermont Health Information Strategic Plan (VHISP)

**July**

1. Finish Grant program
2. Finish telemedicine
3. Updates from ACTT and ACO work- presentations
4. Finish QPM referrals

Attachment 5 - DFR-  
Telemedicine Provided  
Outside A Health Facility

# **Vermont Department of Financial Regulation**

## **Telemedicine Provided Outside A Health Facility: Should Health Insurance Coverage Be Required?**

Report submitted to:  
House Committee on Health Care,  
Senate Committee on Health and Welfare,  
Senate Committee on Finance  
March 6, 2013

**Commissioner, Susan L. Donegan**  
**Deputy Commissioner of Banking and Securities, Thomas J. Candon**  
**Deputy Commissioner of Captive Insurance, David Provost**  
**Deputy Commissioner of HealthCare Administration, David Reynolds**

## **TELEMEDICINE PROVIDED OUTSIDE A HEALTH FACILITY: SHOULD HEALTH INSURANCE COVERAGE BE REQUIRED?**

### **Background**

In 2012, the Vermont legislature passed Act 107 requiring all health insurance plans, both private and public, to provide coverage and reimbursement “. . . for telemedicine services delivered to a patient in a health facility to the same extent that the services would be covered if they were provided through in-person consultation.” Section 6 of the Act also directed the Commissioner of the Department of Financial Regulation to form a workgroup “. . . to consider whether and to what extent Vermont should require health insurance coverage of services delivered to a patient by telemedicine outside a health care facility.” The Commissioner was asked to report the workgroup’s recommendations to the House Committee on Health Care and the Senate Committees on Health & Welfare and on Finance.

The Commissioner formed a workgroup that included 25 members representing the Behavioral Health Network, Bi-State Primary Care Association, Blue Cross/Blue Shield, Cigna, Department of Financial Regulation (DFR), Department of Vermont Health Access (DVHA), Fletcher Allen Health Care, Magellan Health Services, MVP Health Plan, National Council on Compensation, Planned Parenthood, Vermont Assembly of Home Health Agencies, Vermont Council of Developmental and Mental Health Services, Vermont Medical Society, VNA of Chittenden & Grand Isle Counties, Vermont Optometric Association, and Vermont Pharmacist Association. The workgroup met four times by conference call. The use of telemedicine in Vermont since the passage of Act 107 and the status of telemedicine services in other states were examined. As discussed in the recommendation section of this report, *the workgroup members were polled as to their opinion on expanding telemedicine outside of a health facility and there was no consensus on whether to do so.*

### **Telemedicine Use in Vermont to Date**

Medicaid has allowed mental health services to be provided using telemedicine since the fall of 2011. Act 107, requiring private and public insurance coverage for telemedicine services provided in a health facility, took effect on October 1, 2012, for health plans issued or renewed on or after that date. *There has been limited use to date since few plans renew in October.* Based on reports received at the time this report was being written, only eight providers have billed for services to patients provided via telemedicine. Four have billed Medicaid; three have billed Cigna; one has billed MVP; and none have billed Blue Cross/Blue Shield. *This limited use makes it difficult to assess performance and value in terms of considering whether to expand the use of telemedicine in Vermont outside of a health facility.*

## **Other States Use of Telemedicine**

As this report was being prepared, two bills with identical language (S.88 and H.272) were introduced in the 2013 session of the General Assembly that would “provide coverage for services delivered to a patient by telemedicine to the same extent that the services would be covered if they were provided through in-person consultation.” These bills would require insurance reimbursement for services provided from any location equipped with telemedicine capability. *No state has adopted such an expansive requirement on the use, location, and reimbursement of telemedicine.*

That said, legislation mandating private coverage for telemedicine between health facilities is clearly a growing trend. Currently, according to the American Telemedicine Association (2013 State Telemedicine Legislation Tracking), fifteen states do so, and fifteen more have proposals for doing so. Interestingly, fewer states have legislatively mandated Medicaid coverage, though some have done so without legislation. *Regarding requiring telemedicine services outside a health facility, the attached position paper from DVHA indicates that it has not found a state Medicaid program that does.*

Reflective of the fact that coverage and reimbursement for telemedicine are in early stages of adoption, state rules and laws run the gamut in terms of what they allow and/or require of telemedicine in health care facilities. Some permit reimbursement but do not mandate it; others require it for Medicaid, but not private insurance and *vice versa*; some restrict its use for certain conditions or populations or limit the scope of treatment and prescribing allowed. *In short, there is no consensus on the use, regulation, and reimbursement of telemedicine among the states.*

## **Medicare, Medicaid, and Telemedicine Outside a Health Care Facility**

*Medicare does not allow coverage for telemedicine for services outside of a health facility.* As noted in the DVHA position paper, fees for services provided in this way would have to be paid by the patient or be absorbed by the provider. DVHA further indicates that, since Vermont follows Medicare guidelines, it would need to seek CMS approval of a State Plan Amendment in order to cover telemedicine services outside a health care facility. In the event this was not granted, providers would not be reimbursed for such visits by Medicaid and dual eligible populations. *Thus, a significant number of Vermonters enrolled in Medicare would not be covered for telemedicine services provided outside a health care facility, and potentially many Vermonters would not be covered if enrolled in Medicaid.* DVHA noted that it was not able to quantify the potential costs of these services given how little experience it had had to date with services provided via telemedicine and lack of knowledge about who would use these services and how much.

## **Recommendation on Extending Coverage for Telemedicine Outside a Health Care Facility**

The Workgroup members were surveyed to ascertain their opinions on whether they favor:

- expansion of telemedicine services outside a health care facility in the same manner as within a health facility;
- expansion of telemedicine services outside a health care facility with limitations;
- waiting and assessing the current use of telemedicine before expanding its use outside a health care facility; or
- not expanding telemedicine services outside a health care facility.

The result was that, *of the 6 responses received, 2 favored expansion now; 2 favored waiting; and 2 were not in favor of expansion.* Planned Parenthood, favoring expansion now, stated that:

We strongly favor expansion of telemedicine services outside a health care facility in the same manner as within a health facility. Telemedicine is widely considered an easy way to improve care, safety and maximize cost efficiency for health providers. Expanding telemedicine to include coverage outside of a health center will reach some of the most rural Vermonters and ensure that as many people as possible get access to essential health services. Vermonters unable to access public transportation and those without licenses will benefit from this expansion and reimbursement will make it possible to provide this service which many Vermonters will utilize.

In addition to the lack of Medicare coverage and the unknown financial impact, concerns expressed in opposition to expansion of telemedicine services outside a health care facility were:

- research is lacking on out of health care facility telemedicine services that demonstrates an evidence-basis for care delivered this way; and
- there are no clinical guidelines for services delivered this way.

Given the lack of consensus among stakeholders on expanding telemedicine services outside a health care facility, and the lack of data about the potential for use of these services and their associated cost, it seems prudent to hold off mandating this coverage now. That does not mean Vermont should not explore the potential for telemedicine used outside of a health care facility. Given the legitimate interests for improving access and assuring quality care with the use of telemedicine, *pursuing a middle ground is the recommended option.* Vermont is embarked on a wide range of delivery and payment system reforms. Both DVHA and the Green Mountain Care Board are actively engaged in promoting these. In addition, the Blueprint for Health continues its expansion, and Accountable Care Organizations are developing. *DFR recommends that, as part of these initiatives, provision of telemedicine services outside of a health care facility should*

*be considered on a pilot basis.* Doing so would enable targeting of specific populations in need to improve their access while, at the same time, providing assessment of the efficacy of care delivered in this way and promoting the development of clinical guidelines. Vermont would then be able to determine:

- the appropriate scope of services that could/should be provided via telemedicine outside of a health care facility;
- the potential cost of and changes in access to those services, relative to current service delivery; and
- safeguards of quality of care, patient confidentiality, and information security needed if these services are provided.

*DFR encourages both the Green Mountain Care Board, as Accountable Care Organizations emerge, and the Blueprint for Health to consider proposals for pilot telemedicine projects outside a health care facility and to report on their results.* Telemedicine technology may become an important part of the health care armamentarium in Vermont and the state must be ready to use it wisely and well.

DVHA Position Paper  
on  
Telemedicine Services Provided Outside a Health Care Facility  
February 26, 2012

Section 6 of Act 107, passed by the Vermont Legislature in 2012, requires the Department of Financial Regulation to submit a report to the House Committee on Health Care and the Senate Committee on Health and Welfare and the Senate Committee on Finance on whether and to what extent Vermont should require health insurance coverage of services delivered to a patient by telemedicine outside a health care facility.

While the Department of Vermont Health Access embraces the use of telemedicine services, we have concerns about requiring services to be covered when the patient is not in a health care facility.

Telemedicine is in its infancy in Vermont. It is unclear how the use of telemedicine as required in Act 107 will evolve and develop. In most states, telemedicine has been used to address specific provider shortages across the state or in specific geographic areas; no such guidance was included in Act 107. This broad-based approach has created a number of challenges to implement the existing legislation as is and concern regarding unintended consequences as implementation goes forward.

- For example, the original legislation covers any services to the same extent that the services would be covered if they were provided through in-person consultation. While there are telemedicine guidelines for some of those services that is not the case for others we cover and provide. The fact that there are guidelines for some services is an indicator that the provision of those telemedicine services is not the same as the provision of in-person services.
- As this is new, there is uncertainty as to how telemedicine services will be used. It could help increase access to care where there are limited or no providers. At the same time, in some rural areas it could undermine existing specialty referral patterns and revenue for the practice. We may find a few financially marginal specialty practices may choose to close up due to a slight reduction in referrals. While the intent may be to increase access to care, the result could be a loss of local specialty care.

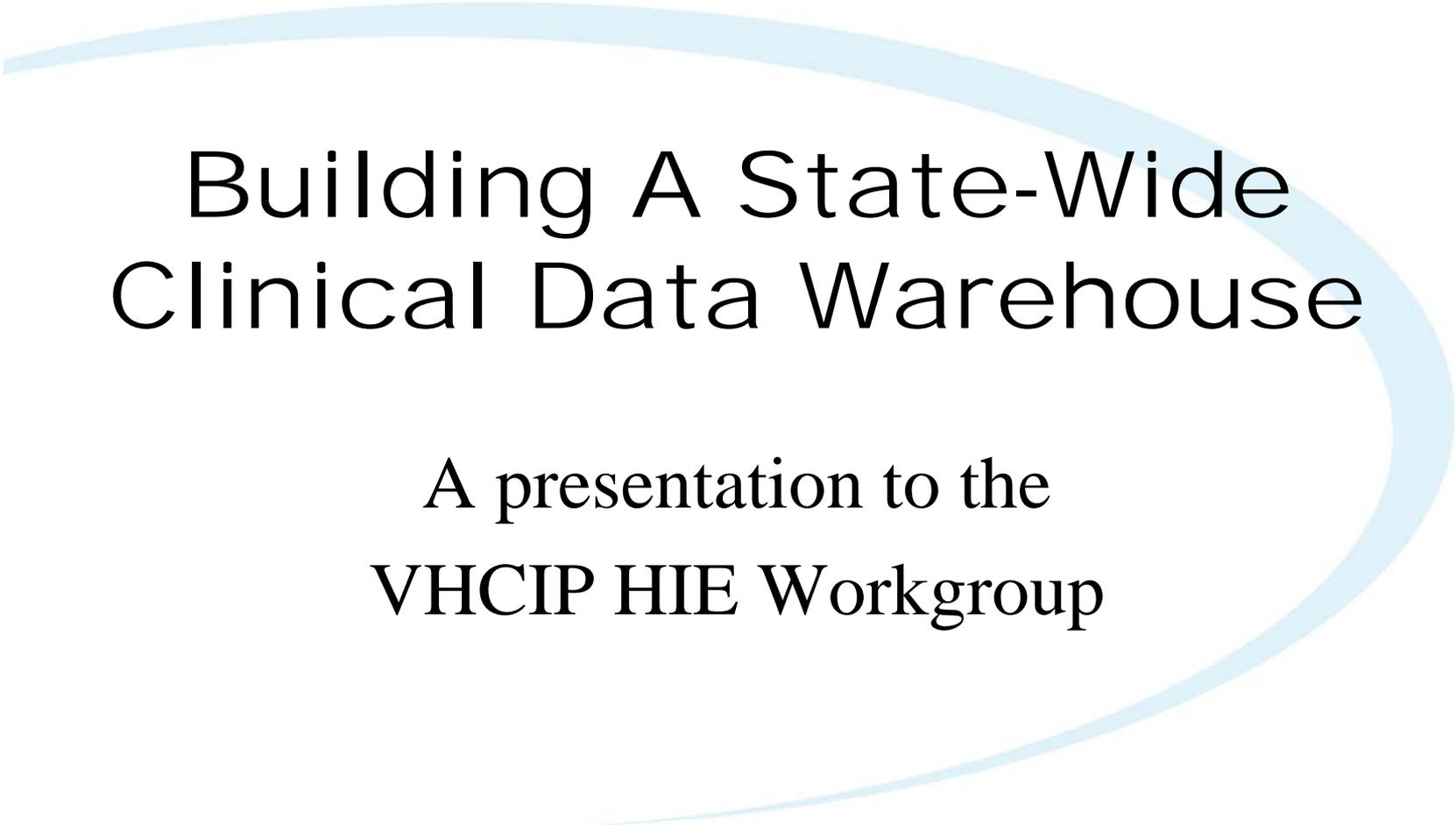
So we believe there is plenty of work to be done implementing the original bill without taking on services outside of a health care facility. Given the Vermont definition of health care facility, outside a health care facility would mean anywhere that does not offer diagnosis, treatment, inpatient, or ambulatory care. That could be at home, work, or some other location where live interactive audio and video are available. DVHA has the following concerns in terms of the provision of telemedicine services outside a health care facility.

- There are no restrictions or limitations in Act 107 as written, such as in underserved areas or where there are provider shortages. If the same standard is applied to services outside a health care facility, a person could choose to have services provided to them in their home for no other reason than personal choice. It raises a question about the value of in-person care versus receiving services at home for convenience.
- There appears to be no published research on the provision of telemedicine services where the patient is outside a health care facility. There are published studies on telemonitoring in the patient's home but none were found on telemedicine. If we want to provide evidenced based care we should have some evidence to follow.
- There also are no clinical guidelines that we have found regarding telemedicine services provided outside of health care facilities.

- We have found no evidence at this time that any state Medicaid program covers telemedicine services outside of a health care facility. The Vermont Medicaid State Plan has followed Medicare guidelines and presently requires that the originating site for telemedicine services to be the offices of physicians or practitioners; hospitals; Critical Access Hospitals (CAH); Rural Health Clinics (RHC); Federally Qualified Health Centers (FQHC); Hospital-based or CAH-based Renal Dialysis Centers (including satellites); Skilled Nursing Facilities (SNF); and Community Mental Health Centers (CMHC). A State Plan Amendment would be required to add any additional language. If no other state Medicaid program has an approved State Plan that allows for services to be provided to an originating site outside a health care facility may run the risk of not being approved.
- We are not sure how to quantify any financial impact. Medicare recipients would have to pay for care or the provider would assume the costs. For those who are dual eligible, since Medicare does not cover services outside a health care facility, Medicaid would cover the costs. As to straight Medicaid, we have very little experience with telemedicine services at this time. Given that, trying to project the financial impact of offering care outside a health care facility is very challenging.
- Lastly, while there may be opportunities to improve health care by offering telemedicine services outside a health care facility, requiring it seems inconsistent with the provision of evidenced-based care, given the lack of published studies or clinical guidelines.

It seems clear to us that the prudent approach is not to recommend any changes to existing legislation at this time.

# Attachment 7 - Building A State- Wide Data Warehouse



# Building A State-Wide Clinical Data Warehouse

A presentation to the  
VHCIP HIE Workgroup



# Background

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- VITL collects clinical data from many VT healthcare organizations today as part of regular VHIE operations
- Over 3M clinical data messages per month now being processed
- Data includes patient demographics, patient events, labs, transcribed reports, medications, immunizations and care summaries

# Background

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- The data collected is used for:
  - Patient identification (MPI)
  - Clinical data at the point of care (VITLAccess)
  - Processing transactions (lab orders, results, immunizations)
  - Populating state registries (Blueprint and VDH)
  - Supporting ACOs clinical data needs

# Why do this project?

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- Aligns with VHCIP Scope (see next slide)
- Would clearly address one of the CMS deliverables
- Strong support from the Blueprint, state agencies, ACOs, hospitals, providers, and others to improve the “quality” of data coming from providers for use in reporting and analytics
  - Data for reporting needs to be complete, accurate and consistent
  - Our experience with the Blueprint identified issues with data reporting
- Would provide a similar capability for clinical data that is currently provided by VHCUREs for claims data
- Would be a step forward in combining clinical and claims data for analysis

# Alignment with VHCIP

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This capability was clearly defined in the VHCIP Scope:

## **Technology and Infrastructure: Integrated Platform & Reporting System Scope**

- Development of an integration repository;
- Development of data management, normalization, person and provider identification, and data merging capabilities;
- Development of reporting portals and dashboards;
- Incorporation of refined analytic methods, algorithms, and reporting formats
- Funds allocated for this: \$2.0M

# Possible Use Cases

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- Blueprint data normalization and data quality improvements
- ACO data normalization and quality improvements for all 3 organizations
- Behavioral Health Network
- Regional Lab Testing Analysis
- Reporting for organizations or groups connected to the VHIE

# Data Flow and Terms

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- Data flows from Source Organizations to the VHIE to the Warehouse and then to Data Marts for analysis
  - Data can be cleaned and improved at each step in the process
- Data Quality is a general term which describes data completeness, accuracy and consistency
- Data Normalization is the process of mapping and converting local terms to common standard terms (i.e. lab test HgA1C to 55454-3)
- Data Marts are subsets of the larger warehouse which can be quickly created to perform specific analytics

# Warehouse Concept

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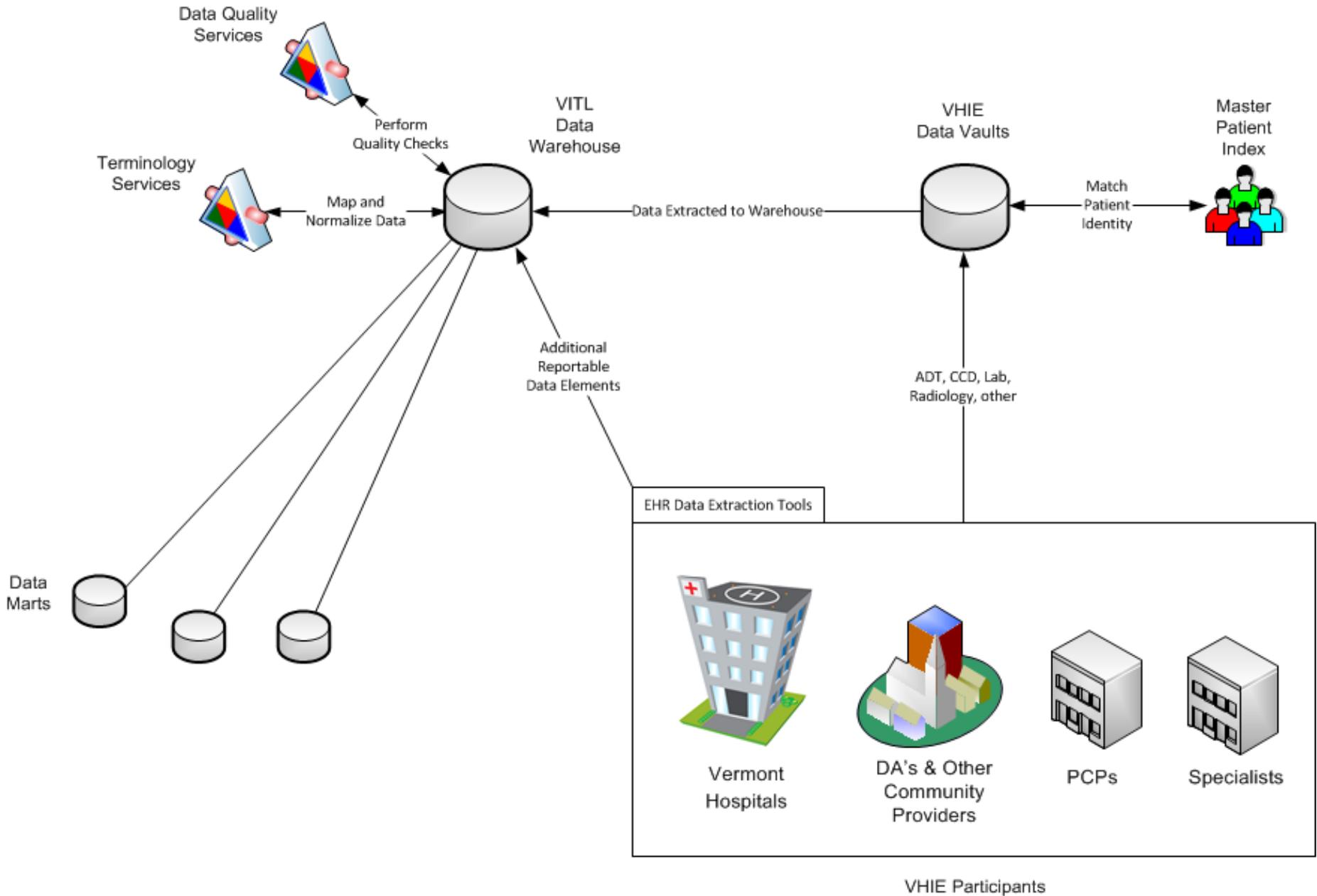
- Use clinical data already collected In VHIE
  - Extract this data to create the warehouse
  - Build the data model
  - Capture live data to keep warehouse current
- Analyze the data for quality and perform “cleansing”
- Perform data normalization to map terms to standards
- From this core warehouse create smaller data sets (marts) for analysis
  - Send these data sets to participant organizations to perform their own analysis, or
  - Provide data reporting and analytics tools for organizations to use

# Details on the Concepts

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- Use clinical data already collected
  - The data collected in the VHIE is not in a form that is ready for reporting and analysis. We need to develop the warehouse for this purpose
- Analyze the data for quality and perform “cleansing”
  - The data then needs to be analyzed for completeness, accuracy and consistency
  - We can then provide a “report card” on data quality for each organization
- Perform data normalization to map terms to standards
- From this core warehouse create smaller data sets (marts) for analysis

# VITL Proposed Data Flow



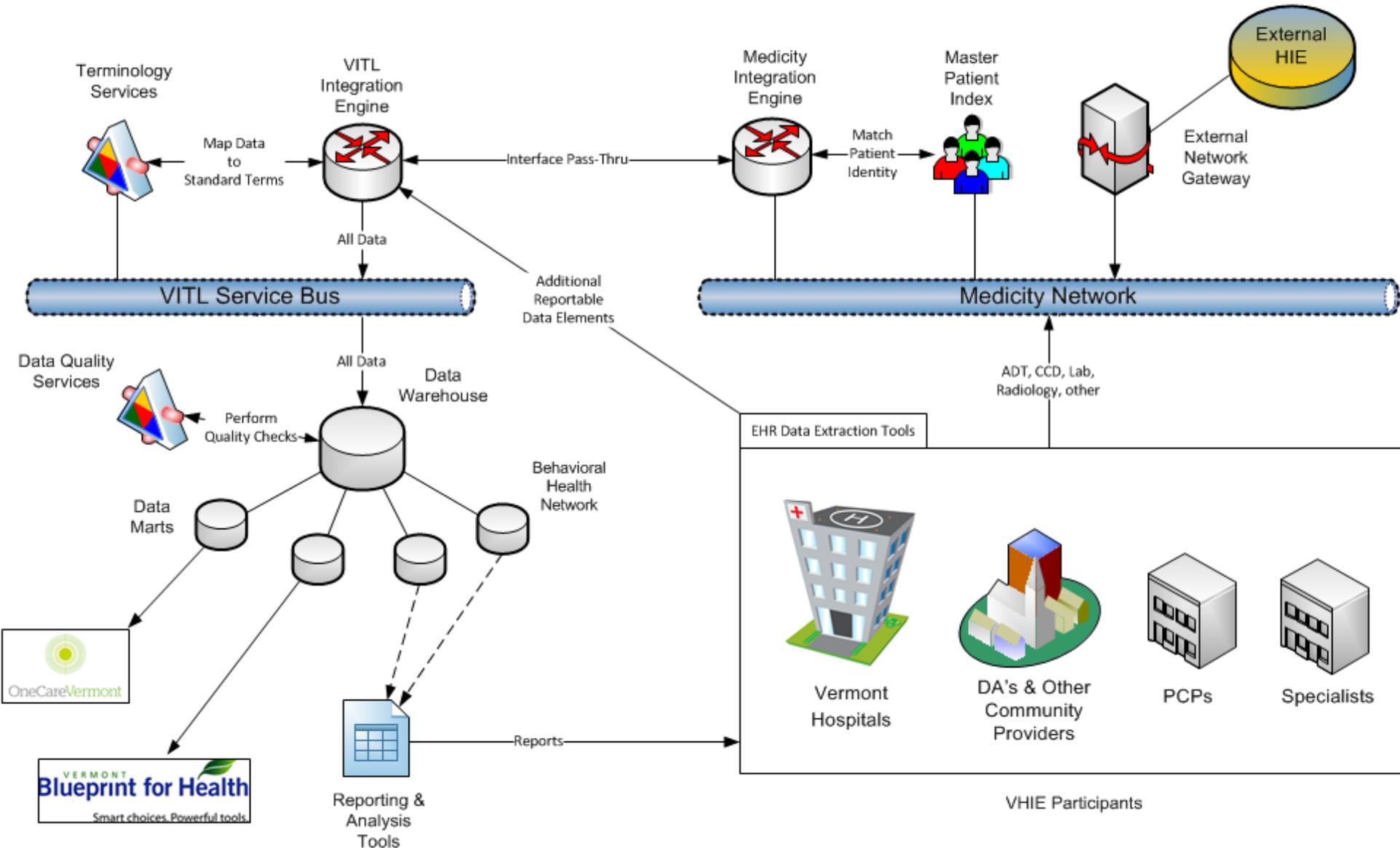
# Components of the Warehouse

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- Core database\*
- Messaging engine\*
- VITL Staff
- Terminology mapping (normalization) services
- Data warehouse with data quality services
- Reporting modules
- Tools for Analytics
- Hardware

\* Already in place

# VITL Proposed Data Warehouse Infrastructure



# Overall Project Costs

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- Estimate the 5 year total cost of clinical warehouse and clinical-claims integration
  - \$9.1M which is in line with VHCIP estimate from grant application
- VITL 5 year estimate for clinical warehouse
  - \$5.5M

# Request for Funds - Phase 1

(Proposed scope through FY16)

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Expense Type	Cost
Staff	\$ 1,109,333
Warehouse Software	\$ 990,000
Consulting	\$ 400,000
Software Subscription	\$ 200,000
Hardware	\$ 216,000
Data Extraction	\$ 100,000
Support	\$ 375,500
Total	\$ 3,390,833
Reductions	
DVHA Funds	\$ (225,000)
BHN using VITL	\$ (140,000)
BHN duplicate services	\$ (384,000)
Total with Reductions	\$ 2,641,833

# Project Timeline

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VITL Data Warehouse Phase 1 Project Timeline									
Task	FY14 Q4	FY15 Q1	FY15 Q2	FY15 Q3	FY15 Q4	FY16 Q1	FY16 Q2	FY16 Q3	FY16 Q4
Data Extraction	█								
Data Feeds	█	█							
Install Hardware		█							
Hire Staff		█	█						
Build Warehouse		█	█	█					
Develop Data Quality Rules			█	█	█				
Install Terminology Engine			█						
Build Data Normalization			█	█	█				
Install Analytics Tools				█	█				
Develop Clinical Data Marts				█	█	█	█		
Start Reporting and Analytics						█	█	█	█

# Future Phase 2 Capabilities and Funding

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- Scope (shorter term)
  - Combined claims-clinical MPI
  - Pilot projects for claims-clinical analysis
- Scope (longer term)
  - Claims–clinical data integration
  - Predictive analytics for disease monitoring and progression
- Funds
  - Approximately \$4-6M additional



Questions?

