Analysis of New Authorizations for the General Bonding Subcommittee

March 6, 2014
10:00 AM

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I. Hearing Schedule

The attached information was developed by OFA staff members for the legislative members of the GO Bonding Subcommittee.

General Bonding Subcommittee Hearings
on Thursday, March 6, 2014

Time	Agency	Analyst	Page
10:00 - 11:00	Office of Government Accountability Office of Policy and Management	Grant Gager Dan Dilworth	2 3
11:00 - 11:30	Department of Labor	Chris Wetzel	9
11:30 - 12:00	Department of Housing	Evelyn Arnold	12
12:00 - 1:00	Lunch		
1:00 - 1:30	Office of Healthcare Advocate	Neil Ayers	14

II. Agency Write-ups

Office of Government Accountability

OFA Analyst: Grant Gager

Description	Unallocated 2/28/14 $	PA 13-239 FY 15 $	Proposed Addition $
Information technology improvements	-	-	1,000,000

OGA did not submit testimony for the Bonding Subcommittee hearing.

Information technology improvements ($1,000,000 proposed by Governor)

Questions:

1. Will the bond funds support the operations of a specific consolidated agency or for OGA's administrative functions?
2. Why is the project necessary? Please explain the current situation and how the project will change that situation. How will the project help OGA achieve its mission? Will the project help OGA to expand its current activities or perform them more efficiently?
3. Please provide a list of the equipment or consultant services that will be purchased with these funds.
4. Will additional funding be needed to complete the project?

Background: The Office of Governmental Accountability (OGA) provides consolidated personnel, payroll, affirmative action, and administrative and business office functions, including information technology associated with these functions, for nine consolidated state agencies. OGA has an executive administrator as its head and each agency in OGA retains its independent decision-making authority, including for budgetary and employment decisions.

The consolidated agencies are the:

- Board of Firearms Permit Examiners (BFPE)
- Freedom of Information Commission (FOIC)
- Judicial Review Council (JRC)
- Judicial Selection Commission (JSC)
- Office of the Child Advocate (OCA)
- Office of State Ethics (OSE)
- Office of the Victim Advocate (OVA)
- State Contracting Standards Board (SCSB).
- State Elections Enforcement Commission (SEEC)

Office of Policy and Management (OPM)

OFA Analyst: Dan Dilworth

Description	Unallocated 2/28/14 $	PA 13-239 FY 15 $	Proposed Addition $
Agency Projects			
Urban Act - Grants-in-aid for urban development projects.	21,847,708	50,000,000	50,000,000
Information Technology Capital Investment Program.	49,944,269	25,000,000	25,000,000
Grant-in-aid Programs			
Transit-oriented development predevelopment fund	-	-	7,000,000
Grants-in-aid to private, nonprofit health and human service organizations that are exempt under Section 501(c)(3) of the Internal Revenue Code of 1986, and that receive funds from the state to provide direct health or human services to state agency clients, for alterations, renovations, improvements, additions and new construction, including health, safety, compliance with the Americans with Disabilities Act and energy conservation improvements, information technology systems, technology for independence, [and] purchase of vehicles and acquisition of property, not exceeding	-	20,000,000	30,000,000

Agency Programs

Urban Act ($21,847,708 unallocated; $50,000,000 in FY 15; $50,000,000 proposed by Governor) – Urban Action Grants are discretionary grants to municipalities that (1) are economically distressed as defined by CGS 32-9p(b), (2) public investment communities or (3) urban centers under the State's Plan of Conservation and Development. Eligible projects include economic development, transit, recreation, solid waste disposal, housing, day care, elderly centers, emergency shelters, historic preservation and various urban development projects.

Question**:** Why is the additional funding necessary?

OPM response: An additional authorization is needed because there are many requests in the pipeline and the level of funding in the bond account is becoming depleted.

Information Technology Capital Investment Program ($49,944,269 unallocated; $25,000,000 in FY 15; $25,000,000 proposed by Governor)

The table shows the OPM's current projection for Information Technology Capital Investment Program spending and the projected level including the proposed additional funds.

IT Capital Investment Program Expenditures – Current and Proposed

Fiscal Year	Current Amount $	Proposed Amount $
2013	25,776,174	18,012,146
2014	24,171,380	59,808,412
2015	26,930,205	36,112,930
2016	12,963,600	15,172,164
2017	2,298,100	4,162,600
2018	-	556,500
TOTAL	**92,139,459**	**133,824,752**

Question 1**:** Why is the additional funding necessary? Is the scope of the current program being expanded?

OPM response: The scope of the current program is not being expanded. An additional authorization is needed to support projects that are being considered for funding. To date, 20 projects totaling $89.7 million have been approved by the Information Technology Strategy and Investment Committee (ITSIC) and the State Bond Commission. An additional 17 projects totaling $44.2 million are being considered for funding. Three of these projects have received ITSIC approval and are pending State Bond Commission approval.

Question 2**:** Please provide a list of how the additional fund will be used.

OPM response: The additional funds will be used on investments that meet the following strategic priorities:

1. Make state government more user-friendly and efficient for citizens, businesses and municipalities when transacting business with the state, including areas related to obtaining permits, licenses, paying taxes or accessing services;

2. Make information about services and state government more available and easy to find on-line;

3. Implement efficient, modern business practices that result in clear and identifiable cost savings and service delivery improvements for state agencies;

4. Increase transparency for policy makers and the public regarding costs, effectiveness and service outcomes within and across state agencies;

5. Reduce the cost to the state for the implementation, use and management of technology systems through shared services, applications and hardware across agency boundaries and by other means;

6. Implement systems needed to support health-care reform, manage costs and improve outcomes related to the state's health and human service programs; and

7. Ensure the appropriate level of confidentiality, integrity and availability of the state's electronic or digital data information resources in order to provide an environment in which the state's user community can safely conduct state business.

Background: The Information Technology Capital Investment Program is a five-year plan to update and consolidate the state's information technology (IT) infrastructure. Currently, state agencies use a variety of decentralized IT systems that are generally incompatible and outdated, which prevents agencies from communicating efficiently and effectively with other agencies.

Grant-in-aid Programs

Transit-oriented development predevelopment fund ($7,000,000 proposed by Governor)

Question 1: Please describe the program. What is its purpose?

OPM response: The funds will be used to provide financing to municipalities, housing authorities and developers interested in developing properties for housing and mixed use projects around the two new transit corridors (New Haven-Hartford-Springfield Rail and CT Fastrak[1]), as well as to make housing and infrastructure improvements in those communities. The funds can be used:

- For predevelopment activities, such as environmental inspections, geotechnical studies, market studies, architectural and engineering design, real estate appraisals, and associated legal services.
- To directly provide financing for site control and/or acquisition or to carry out housing or infrastructure improvement projects and other needs identified in communities along the two transit systems.

The request needs to be altered slightly. The intent was not to limit the funds to be applied to the previously authorized predevelopment fund (see Question #2 below). Based on a

[1]CTfastrak is the 9.4-mile bus rapid transit system between New Britain and Hartford. Construction began in May 2012. It is scheduled to open for passenger service in early 2015.

$1 million allocation from the State Bond Commission, a request for quote (RFQ) was issued for the predevelopment fund, a fund manager was chosen, and contract negotiations are underway between DECD and the fund manager. While a small portion of this new request may be used to provide additional capital to the predevelopment fund, with a similar private sector matching requirement, the intent is to use the majority of these funds for housing and infrastructure projects that will advance transit-oriented development activities in municipalities.

Question: Please describe the alteration that needs to be made to the request.

Question 2: OPM currently has a $1 million unallocated balance for "Funding to capitalize a transit-oriented predevelopment fund provided that $2 million in matching funds is raised by a public-private partnership". What is the current status of those funds?

OPM response: As indicated in the response to Question #1, a fund manager was selected through an RFQ process and discussions are underway at DECD to develop the contract and establish the fund.

Question 3: What are the eligibility criteria for applicants and projects?

OPM response: For the predevelopment fund, it is unknown at this time and is pending negotiations with the fund manager. For the funds requested in the capital budget revisions, OPM will speak to municipalities, developers and other interested parties to determine what the unmet need is for transit-oriented development in communities along the CT Fastrak and New Haven-Hartford-Springfield rail line. OPM will use that information to establish the criteria.

Question 4: Is there a cap on the amount of funding available to each applicant?

OPM response: For the predevelopment fund, it is unknown at this time and is pending negotiations with the fund manager. For the funds requested in the capital budget revisions, OPM expects to have discussions with municipalities, developers and other interested parties before setting any limitations. Data gathered on unmet needs and interest in the funds will inform any decision on a cap.

Question 5: How will applications be evaluated and prioritized?

OPM response: For the predevelopment fund, it is unknown at this time and is pending negotiations with the fund manager. For the funds requested in this budget, OPM expects to have discussions with municipalities, developers and other interested parties before setting any criteria.

Question 6: Who will administer the program?

OPM response: OPM will administer the program, as well as coordinate all transit-oriented development (TOD) activities among the various state agencies.

Grants-in-aid to private, non-profit health and human service organizations (no unallocated; $20,000,000 in FY 15; $30,000,000 proposed by Governor)

Question 1: Why is the additional funding necessary?

OPM response: OPM received 553 applications from 275 different nonprofit providers by the October 18, 2013 application deadline[2]. The amount requested exceeded $100 million, which far exceeded the $20 million that was authorized for this program in FY 14. OPM's evaluation committee[3] is nearing finalization of the list of proposed grant awards for the first $20 million authorization. The evaluation committee indicated that a large number of strong applications will not be funded in FY 15 because the requested amount exceeds the second $20 million authorization. In addition, OPM believes that future application rounds for this program will continue to result in project submittals that far exceed the $100 million total received in FY 14.

Question 2: Why are the proposed language changes necessary? How will the changes affect eligibility for the program?

OPM response: The new language adds organizations that "receive funds from the state to provide direct health and human services" to the eligibility criteria. This was considered necessary to reflect the intent of this program, which is to improve the efficiency, effectiveness, safety and/or accessibility of health and human services being delivered by the state, and to state-agency clients, through its network of nonprofit providers. The provision covering the acquisition of property is being added for providers who can gain efficiencies by purchasing rather than renting space.

Question 3: What is the application process for the program? How does OPM evaluate and prioritize the applications?

OPM response: OPM's program guidelines can be found on the agency's website: http://www.ct.gov/opm/cwp/view.asp?a=2978&q=530538&opmNav=.
The guidelines address the following:

- eligible applicants, projects and costs;
- application content, process and timeframes;
- application evaluation and selection criteria and process; and

[2]The request for applications was posted on the OPM and the Department of Administrative Services websites on August 21, 2013.
[3]The OPM evaluation committee was established by the Secretary of OPM in accordance with the program's guidelines. The members include two staff members from OPM and representatives from State health and human service agencies.

- post-selection processes, including those related to grant award contracts for selected applicants and projects.

Following receipt of applications by the October 18, 2013 deadline, they were screened for eligibility and then reviewed and scored by the OPM evaluation committee. The evaluation committee then submitted its recommendations to the Secretary for his review and acceptance.

Question 4: Is there a cap on the amount of funding that each applicant can receive?

OPM response: According to the program guidelines developed by OPM, grant awards will be limited to generally no more than $1.0 million for any project or nonprofit provider per year.

Question 5: How did the state previously provide funding to those organizations for such purchases?

OPM response: In the past some agencies, such as the Departments of Children and Families, Mental Health and Addiction Services and Social Services, received direct capital appropriations for their providers, mostly limited to specific code compliance needs, health and safety and ADA compliance. The Department of Developmental Services has a loan program that has been utilized by providers on a relatively modest basis. The goals of the OPM program are to improve the efficiency, effectiveness, safety and/or accessibility of health and human services being delivered by nonprofit organizations. These goals are broader in scope than the capital funds given to service providers by individual state agencies.

Question 6: What is the estimated number of organizations that are eligible for the program?

OPM response: Based on the number of health and human services contracts and agreements that State agencies have with nonprofit providers, OPM estimates that 700 to 800 organizations would be eligible for the program.

Background: The funds are used to provide grants to private, non-profit health and human service organizations that can be used for alterations, renovations, improvements, additions and new construction, including health, safety, compliance with the Americans with Disabilities Act, energy conservation improvements, information technology systems, technology for independence or vehicle purchasing. In addition to increasing the funding for this program, changes proposed by the Governor for FY15 are: 1) add receiving state funds to provide health and human services to state agency clients to the provider eligibility criteria and 2) add acquisition of property as an eligible project.

Department of Labor

OFA Analyst: Chris Wetzel

Description	Unallocated 2/28/14 $	PA 13-239 FY 15 $	Proposed Addition $
Agency Projects and Programs			
Subsidized Training and Employment Program (STEP-UP)	-	-	10,000,000

Agency Projects and Programs

Subsidized Training and Employment Program (STEP-UP) ($10,000,000 proposed by Governor)

The table below indicates the number of firms and workers that participated in the prior two rounds of STEP-UP program funding:

STEP-UP Program Participation

STEP-UP Funding Round	Firms	Workers
Round 1: February 2012 thru June 2013	506	1,660
Round 2: July 2013 thru February 27[4] (to date)	128	535
TOTAL	**634**	**2,195**

Question 1: What percentage of workers continued to be employed beyond the six-month subsidized training period?

DOL response: Of the 2,195 participants in the STEP-UP program, 52.3% completed the six-month STEP-UP program. Of those workers who completed the six months of subsidized employment, 97% were employed with the participating company one month after the completion of the STEP-UP program.

Question 2: Are there any unspent STEP-UP funds remaining from the initial $20 million bond allocation?

DOL response: After administrative cost, a total of $18,446,000 was budgeted into the STEP-UP program to fund subsidized wages for participants of the program. As of February 26, 2014 a total of $4,991,924 remains unspent. The remaining unobligated funds is a total of $2,890,774.

Question 3: What indications does DOL have regarding the current level of interest in additional STEP-UP funding? How many companies have contacted DOL?

[4]Round 2 of the Step-Up program ends June 2014.

DOL response: The Department of Labor has planned six STEP-UP informational conferences for employers. The STEP-UP conferences are planned for Danbury, East Hartford, Westport, Bristol, Torrington and Simsbury. Approximately 800 companies have contacted the Department of Labor with regard to STEP-UP, which does not include employers that have contacted the STEP-UP Coordinator in their region for additional STEP-UP information. Based on contact made with companies there does appear to be more interest from manufacturing companies.

Question 3: Does DOL plan to make any changes to the STEP-UP program if the additional $10 million is authorized? How much of the $10 million will be used for grants under Small Business STEP-UP and Small Manufacturer STEP-UP? What will be the average hourly wage of workers hired: (a) under the Small Manufacturers portion of the program and (b) under the Small Business portion of the program? How much will be used by DOL for administrative costs?

DOL response: DOL would like to increase the percentage of STEP-UP funding for the Small Manufacturing STEP-UP by 10%, thus decreasing the Small Business portion. The current program's average hourly wage for Manufacturing is $15.03 and the average for Small Business is $14.08. DOL believes the figures will be similar if the program is extended.

Statutory language currently provides 4% to the Workforce Investment Boards and 4% to the Department of Labor for administration and marketing of STEP-UP.

Background: STEP-UP provides grants-in-aid to small businesses and manufacturers to subsidize on-the-job training costs during an eligible employee's first six months. PA 11-1 of the October Special Session authorized $10,000,000 in each of FY 12 and FY 13 for STEP-UP. The State Bond Commission allocated the first $10 million for STEP-UP in January 2012 and the second $10 million in March 2013.

The five regional Workforce Investment Boards administer the program. As of June 2013, 491 employers had hired 1,650 workers. The average hourly wage of workers hired under the Small Manufacturers portion of the program was $14; the average hourly wage of workers hired under the Small Business portion was $15.50.

Small Business STEP-UP Grants - Eligible small businesses can receive grants if a new employee:

- Was unemployed immediately before hire,
- Lives in a municipality with either (a) an unemployment rate at least as high as the state unemployment rate as of September 1, 2011 or (b) a population of 80,000 or more and
- Has a family income under 250% of the federal poverty level, adjusted for family size.

Employers can receive grants subsidizing a percentage of a new employee's training and compensation. The percentage subsidized diminishes over the employee's first 180 days on the job. The maximum subsidy is $20 per hour.

The table below shows the subsidy level schedule for the program:

Small Business STEP-UP Program Subsidy Schedule

Period	% of cost subsidized per eligible employee[5]
Days 1-30	100%
Days 31-90	75%
Days 91-150	50%
Days 151-180	25%

Small Manufacturer STEP-UP Grants - Eligible small manufacturers can receive grants if an employee is newly hired. The manufacturer must provide any necessary training at the job site, but there are no additional residency, unemployment or previous employment requirements.

These grants subsidize the costs of new employee training and compensation up to a fixed monthly limit that phases out over time. No individual grant can exceed the employee's salary, or total more than $12,500.

The table below shows the subsidy level schedule for the program:

Small Manufacturer STEP-UP Program Subsidy Schedule

Month of Employment	Maximum cost subsidized per eligible employee $
1	2,500
2	2,400
3	2,200
4	2,000
5	1,800
6	1,600

[5]Maximum of $20/hour

Department of Housing

OFA Analyst: Evelyn Arnold

Description	Unallocated 2/28/14 $	PA 13-239 FY 15 $	Proposed Addition $
Agency Projects and Programs			
Shoreline resiliency fund	-	-	25,000,000

Agency Projects and Programs

Shoreline resiliency fund ($25,000,000 proposed by Governor) –

Question 1: Please describe the program. What is its purpose?

DOH response: Super Storm Sandy demonstrated the benefits of elevating homes and businesses. Unfortunately, most citizens do not possess the funds necessary to elevate their homes. This fund would provide low-interest loans to those whose homes and businesses are subject to coastal flooding, and would like to take an active role in preparing for the next storm by elevating their residence or business. Wind retrofits will also be eligible, but not required.

Congress passed the Biggert-Waters Flood Insurance Reform Act in 2012, which will increase flood insurance premiums dramatically. Some residents expect to see rate increases of up to 25% a year until the rates reflect true risk. Elevating a home would stave off these increases, and some would actually see lower rates than what they currently pay. Failure to help homeowners and businesses on the state's shore could make coastal homes uninsurable and unsalable.

The Shoreline Resiliency Fund is designed to leverage private sector investment by using state funds to attract private sector dollars into a fund that would be managed by a nonprofit lender. The State Bond Commission allocated $2 million in Urban Act funds for the Shoreline Resiliency Fund, to allow the program to get started as soon as a fund manager is selected. The Department of Housing (DOH) issued an RFP to select a fund manager and that RFP will remain open until mid-March 2014. Once a fund manager has been selected, the DOH will work with the fund manager to set up the fund. The additional $25 million in the proposed capital budget revisions is necessary to leverage significant private sector investment in the fund.

Question: How much is the required match from the property owner?

Question 2: What are the eligibility criteria for applicants?

DOH response: All decisions are contingent on negotiations with the selected fund manager. At this time, the DOH expects that to be eligible for a loan, homeowners and

business owners' structures must be subject to coastal flooding and located in either Zone VE or Zone AE as defined by the Federal Emergency Management Agency (FEMA)[6] and National Flood Insurance Program. The Shoreline Resiliency Fund will allow property owners to elevate or flood-proof primary and secondary single family homes, 1 to 4 unit owner-occupied rentals and businesses. There is no income cap for applicants.

Question 3: What are the eligibility criteria for projects?

DOH response: All decisions are contingent on negotiations with the selected fund manager. At this time, DOH intends to require all projects to meet the same strict standards that homeowners and businesses must meet when they seek Hazard Mitigation Funds from the state Division of Emergency Management and Homeland Security (DEMHS)[7]. DOH has consulted with DEMHS throughout the development of this program, and expects that DEMHS will continue to work with DOH and the selected fund manager to structure the steps necessary to complete an evaluation.

Question 4: Is there a cap on the amount of funding available to each applicant?

DOH response: Loans of up to $300,000 per applicant will be permitted.

Question 5: How will applications be evaluated and prioritized?

DOH response: This is undetermined at this time and will be subject to discussions that will need to take place with the selected fund manager once the level of funding is finalized. The level of funding requested, to be matched by the private sector, would most likely allow applications to be funded on a rolling basis.

Question 6: Who will administer the program?

DOH response: The Department of Housing has issued an RFP for a non-profit lender to administer the program.

[6]The Federal Emergency Management Agency determines flood risk for the United States and creates maps to clearly show the geographic areas prone to flood. Zone AE is commonly referred to as the base flood area or the 100-year flood plain. Because flood zone AE is prone to flood, property owners in these zones must buy flood insurance if they live in a community that participates in the National Flood Insurance Program (NFIP). Since VE Zones are areas subject to flooding with high velocity wave action that is greater than 3 feet in height, building codes are much more restrictive than AE Zones.

[7]DEMHS is part of the Department of Emergency Services and Public Protection and homeland Security.

Office of the Health Care Advocate

OFA Analyst: Neil Ayers

Description	Unallocated 2/28/14 $	PA 13-239 FY 15 $	Proposed Addition $
Development, acquisition and implementation of Health Information Technology systems and equipment in support of the State Innovation Model	-	-	1,900,000

Agency Project

Development, acquisition and implementation of Health Information Technology systems and equipment in support of the State Innovation Model ($1,900,000 proposed by Governor)

Question 1: What is the State Healthcare Innovation Plan?

HCA response: The Connecticut Healthcare Innovation Plan ("Innovation Plan")[8] is a state-based model for multi-payer payment and healthcare delivery systems. It is currently being funded by a $2.85 million federal grant from the Center for Medicare and Medicaid Innovation (CMMI) as part of CMMI's State Innovation Model (SIM) initiative. The major elements of the plan are projected to begin on July 1, 2015, following a nine-month design phase (1/1/14 through 9/30/14) and a pre-implementation phase (10/1/14 through June 30, 2014). A copy of the Innovation Plan is available at www.healthreform.ct.gov.

HCA intends to apply for an additional test grant from CMMI to implement elements of the Innovation Plan. HCA anticipates that CMMI will accept applications for grant funding of between $40 and $60 million per state within the next month, with awards anticipated in the latter part of calendar year 2014.

Background: The goal of Connecticut's plan is to improve the healthcare quality and the healthcare experience while reducing disparities in care and the trend in healthcare-related expenditures. It covers services funded by Medicaid, Medicare, commercial health plans, or self-funded employers and is being designed to reach primary care providers, community health services and consumers. The plan is supported by initiatives in the areas of performance transparency, value-based payment, health-information technology and workforce development.

[8]The plan was developed under the guidance of the Lieutenant Governor and the Healthcare Advocate with stakeholder participation.

Question 2: Why is the project necessary? Please explain the current situation and how the project will change that situation.

HCA response: The project focuses on the use of health information technology in the areas of healthcare delivery, payment and consumer access (see Appendix A for more information). Some of the project's activities are already fully or partially funded (electronic health record (EHR) adoption, all payer claims database). HCA is requesting the $1.9 million bond authorization in addition to applying for the CMMI test grant. HCA's work on the Connecticut Healthcare Innovation Plan will continue whether or not additional CMMI grant funding is received.

Question 3: Please provide a list of the equipment or consultant services that will be purchased with these funds.

HCA response: Please see the table below:

Use of Proposed Bond Authorization for HCA

Description	Equipment $	Consultant $	TOTAL $
DIRECT messaging consent registry, regional connectivity and identify management	200,000	800,000	1,000,000
Cross-payer claims analytics engine using edge server technology	400,000	400,000	800,000
e-consult – software license and configuration	100,000	-	100,000
TOTAL			1,900,000

Question 4: Are there any FY 15 operating budget adjustments that are linked to this proposed bond authorization?

HCA response: In addition to $1.9 million proposed bond authorization, the Governor's proposed FY 15 revisions to the operating budget include:

- $3.2 million in the Office of the Healthcare Advocate to fund staff and vendors to consult on quality measurement, performance transparency, health improvement, workforce development, stakeholder and employer engagement, evaluation and project management, and
- $65,000 in the Office of the State Comptroller for a healthcare analyst.

The Office of the Healthcare Advocate will coordinate the establishment of a Health Information Technology (HIT) Oversight Council, which will be co-chaired by Commissioner Roderick Bremby and supported by Connecticut's HIT Coordinator. The Governor's proposed operating budget for the Office of the Healthcare Advocate provides funding for a full time health information technology specialist to support the proposed activities and the work of the Council.

Question 5: Will additional funding be needed to complete the project?

HCA response: Please see the table below:

Future Requirements for Projects and Systems Receiving Proposed Bond Funds

Description	Future Funding Requirements
DIRECT messaging consent registry, regional connectivity and identify management	Additional operating funds will be needed for staff associated with the consent registry, approximately 2-3 FTE[9] per annum.
Cross-payer claims analytics engine using edge server technology	Bond funds will cover initial set up, configuration, and the production of basic cross-payer reports. Additional development costs to support advanced analytics and data visualization tools will be required in future years, subject to the availability of test grant funds.
e-consult – software license and configuration	Bond funds will support set-up for CY15 demonstration. SIM test grant funding will be sought for statewide expansion and practice support for integration of technology into practice workflow.

[9]Full Time Equivalents.

Appendix A
Additional Information from the Office of the Health Care Advocate

1.7 CURRENT HEALTH INFORMATION TECHNOLOGY (HIT) LANDSCAPE

Electronic Health Records and Health Information Exchange

The Health Information Technology for Economic and Clinical Health (HITECH) act, enacted as a part of the American Recovery and Reinvestment Act of 2009 (ARRA), provides funds to small, privately-owned primary care practices, federally-qualified health centers (FQHCs), critical area access hospitals, and other community health centers to stimulate the adoption of health information technologies. These technologies include electronic health records (EHRs), e-prescribing systems, and laboratory information systems. Funding was made available to all states through multiple initiatives, such as the health information technology extension program, state health information exchange cooperative agreement program, and community college consortia to educate health information technology professionals program. C.1 future hit landscape

The Office of the National Coordinator (ONC) has invested approximately $30 billion to implement the HITECH Act. The Health Information Technology Extension Program provides each state the funds to increase the EHR adoption rate among its physicians. Similarly, under the HIE program, states are expected to build infrastructure and mechanisms that support the exchange of health information among physicians' offices, hospitals, laboratories, pharmacies, registries, etc. Additionally, the state of Connecticut has established a functional health insurance marketplace and is a Medicaid expansion state. As of November 2013, the State of Connecticut received over $278 million through the various HIT initiatives funded through the Department of Health and Human Services (HHS).

Currently, some 54% of the practicing physicians have adopted certified EHRs, a significant increase from 37% in 2011. Also, over 5,000 eligible professionals and all hospitals have received payments for adoption of EHRs and many have attested to achieving Meaningful Use Stage 1. Additionally, 96% of the pharmacies are enabled for receiving e-prescribing. However, lab interoperability is low, with only 40% of the physicians having the ability to order and view laboratory results electronically.

EXHIBIT 12: Change in EHR Adoption among Physicians between 2008 and 2013

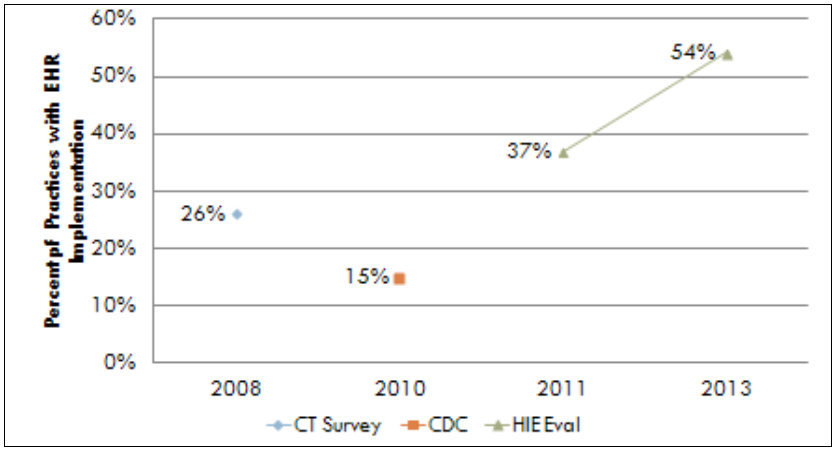
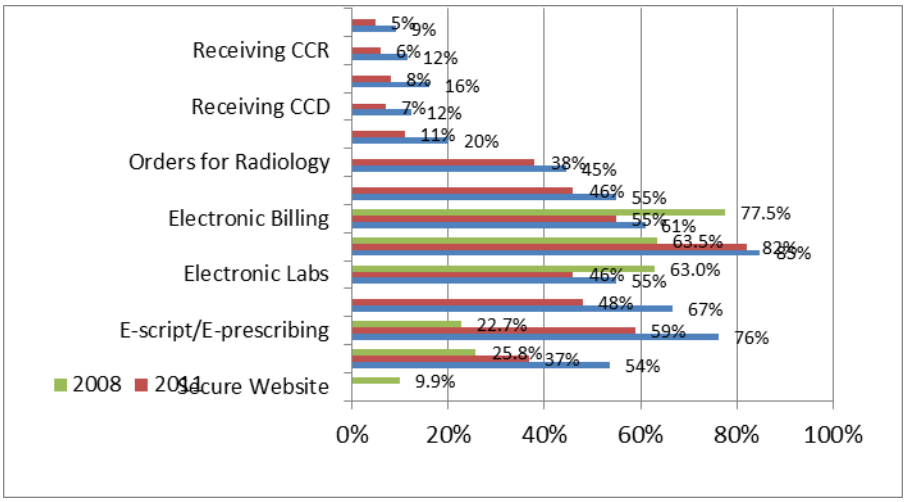


EXHIBIT 13: Current Use of IT Components

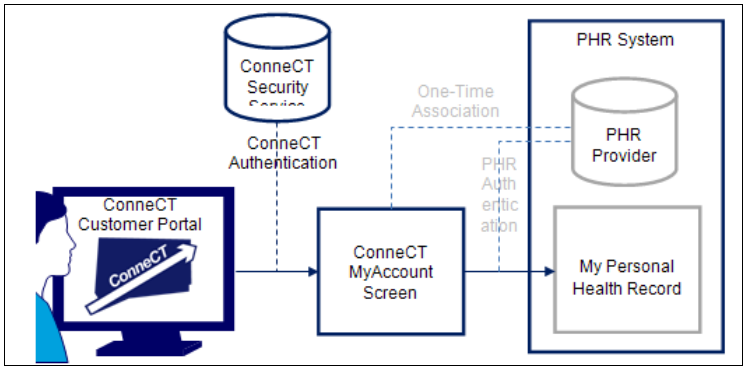


Many HIT initiatives have been evolving simultaneously and hence have not had the benefit of sequencing. Progress on HIE has been slow, particularly in systems interoperability that permit timely sharing of health information. This slow progress can be traced to misaligned funding streams that contributed to the lack of coordination among many HIT initiatives. Our state will see a substantial change in the exchange of health information over the next two years once providers have EHRs that are certified. The rate of EHR adoption is projected to be at 75% by the year 2015 based on current national trends.

Also, the Health Information Exchange of CT (HITE-CT), the Connecticut's designated HIE, is purchasing the Provider Directory and Enterprise Master Patient Index (EMPI) that are the building blocks for the operation of a statewide exchange. The Department of Public Health is working toward being able to accept electronic messages into its immunization registry and is exploring purchasing a syndromic surveillance system in the next year.
Additionally, the Department of Social Services (DSS) is working on many key HIT initiatives. First, the agency is enabling the use of Direct Messaging protocol to send messages between providers and/or systems to enhance care-coordination for an array of program services, e.g., dual-eligibles (Medicare/Medicaid), Patient Centered Medical Home (PCMH) model, long term

post-acute care provider network) by ensuring exchange of documents, e.g. discharge summaries, assessments, and continuity of care. Second, DSS is developing an integrated Eligibility System which will provide a consumer interface with the health insurance marketplace by December 2015. Third, DSS is exploring the possibility of allowing Medicaid beneficiaries the option to connect to a Personal Health Record (PHR) using the same user name and password they establish to sign into the integrated eligibility portal. Fourth, DSS will use Quality Reporting Document Architecture (QRDA) Category III standards for receiving eClinical Quality Measures as one option in their EHR Incentive program. Lastly, DSS has applied for a planning and demonstration grant for Testing Experience and Functional Tools (TEFT) in Community-Based Long Term Services and Supports that demonstrate the use of standards (content and transport) to improve the care coordination and service delivery in community-based long term care. Together these initiatives will operationalize the *no wrong door* concept as people access health care. These initiatives will also move us from single use to enterprise use technologies based on standards for both content and transport.

EXHIBIT 14: Use of HIT Components: TEFT Grant proposal



All Payer Claims Database (APCD)

APCDs are an essential tool for revealing differences in price and performance for state healthcare systems. Access Health CT is developing an APCD to collect, assess and report healthcare information that relates to safety, quality, equity, cost-effectiveness, access and efficiency. When complete, the APCD will:

- Create comparable, transparent information
- Provide consumer tools that enable consumers to make informed decisions with regard to quality and cost of services
- Promote data element standardization so that data can be compared across the state and nationally
- Facilitate the broader policy goals of improving quality, understanding utilization patterns, identifying disparities along the continuum of care especially for ambulatory care sensitive conditions, enhancing access and reducing barriers to care
- Enable the aggregated analytics that can inform public policy and reform

The APCD was authorized under Public Act 12-166, to receive PHI ("protected health information") data from various carriers via a state mandate, including public payer data like Medicaid and Medicare. This mandate further instructs use of the APCD "(1) to provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions, (2) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services, researcher or the Connecticut Health Insurance Exchange for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. Such disclosure shall be made in a manner to protect the confidentiality of health information, as defined in 45 CFR 160.103, and other information, as required by state and federal law."

The APCD will be a large database from multiple payers, which can act as an anchor to create a centralized repository of other data sources – HIE, Master Provider Index, payer analytics/reports, provider analytics, care management and other intervention program metrics and analytics, and create other value added information like episode grouping, risk profile of patients, quality metrics derived from evidence based medicine, pharmacy utilization, etc.

APCD has three defining characteristics – historical claims data, connectivity keys based on members' identification which links disparate data from variety of sources, and analytic capabilities. These three characteristics will be important for the success of the SIM project.

In order to implement the APCD, CT has drafted a Data Submission Guide (DSG) that describes the data elements and formats for required data files and is being refined based on stakeholder feedback. The policy and procedures based on the DSG have also been drafted and will undergo legislative review. First data submission will begin in the spring of 2014 with a plan to be operational by late summer 2014.

The main initial focus will be to create information for consumers using Connecticut's health insurance marketplace, and other consumers as well. Anticipated functions include the following: (i) transparency tools that illustrate the cost of various services offered by physicians, hospitals, outpatient departments or independent labs/radiologic services, (ii) tools for selecting the best places to go for services within a geographic area, (iii) tools for finding the highest value providers, i.e., those that offer the lowest cost but highest quality medical services, (iv) tools for choosing the right insurance product for the family, (v) tools for reporting and visualizing how healthcare is disseminated within the state, highlighting geographic, race/ethnic (if available), payer (e.g., Medicaid versus commercial) variations, and lastly (vi) tools that enable researchers to investigate other topics to add to our growing body of healthcare knowledge.

Connecticut is in the process of formulating additional policies and procedures regarding data use, privacy and security issues. It is contemplated that APCD will be able to share data with various entities both private and public, as allowable under the strict guidelines of HIPAA regulations. Under the allowable guidelines we can use both de-identified and limited data sets for various research activities and cost transparency reporting, provided the member

identification is never compromised. We also recognize that various types of research involving 'treatments and coordination of care' by non-public health state projects/agencies may require patient consents as a prerequisite for data use. We intend to formulate data use and privacy rules that will accommodate sharing PHI information on a case by case basis as may be necessary in the SIM project, subject to consumer consent consistent with the HIE data sharing principles.

All these assets are available to the SIM initiative for re-use. The technologies and systems are designed with the capability of scaling to enterprise requirements. Should the Healthcare Innovation Steering Committee decide to use any or all parts of HIT components being deployed, they will have a foundation upon which to build rather than being forced to procure, assemble and deploy these assets anew.

For the SIM initiative to be successful in harnessing the power of HIT there is work to be done on the developing Data-Use and Reciprocal Support Agreements (DURSA) across agencies and public-private enterprises. Some initial work was completed in 2009 by DSS (supported by a CMS transformation grant), that produced a 30-page DURSA that was signed by three FQHCs and one hospital. This agreement should be used as a starting point for any future work, as this approach presents the possibility of operationalizing data driven decision making sooner.

We will need to identify the best possible way to maintain informed consent with the goal being to design and implement a system that makes it easy for consumers to grant and revoke consent for sharing their health information across systems. One possible solution is a consent repository that can be queried by all participating providers to assess consumer consent status, potentially linked with the EMPI. There may be other solutions that will be evaluated, but having a clear and actionable informed consent process is critical to the success of any HIT solution aimed at improving the care experience.

The ongoing consumer survey that was initiated in 2011 to gauge Connecticut residents' perception and intent to use HIT provides us with some insight into the level of engagement of our residents. A sample of randomly selected household telephone numbers generated over 600 responses. Respondents were predominantly white (80%) and female (65%) with a mean age of 58. Most (80%) reported being in excellent or good health and 89% were satisfied with their primary care provider (PCP). One in four respondents reported familiarity with HIE, 50% reported familiarity with the EHRs, 21% reported familiarity with a personal health record (PHR), and 23% reported being interested in getting a PHR. It was interesting to note that 24% of respondents reported being interested in sharing their health information via an EHR and 33% reported being somewhat interested in sharing their health information. Almost 70% expressed support for a National HIE. Nearly two-third (63%) of respondents expressed support for an opt-in model which is different from the opt-out model that was adopted by HITE-CT. In response to questions about reasons that people were disinterested in use of HIT, the most commonly cited reasons for disinterest were related to privacy and security concerns.[10]

[10]Tikoo, 2013, http://cicats.uchc.edu/wp-content/uploads/2013/04/Frequency_ConsumerSurvey_201307011.pdf

4. Health Information Technology

Health Information Technology (HIT) has the potential to enable primary care transformation, community health improvement, and consumer empowerment, if positioned and leveraged in a meaningful way. Much has been written about the advantages of using HIT and Health Information Exchanges (HIEs) and their resulting benefits to improving quality of care, patient safety, and efficient care delivery. For instance, capabilities such as direct messaging between providers will promote provider communication across settings; payer and provider access to integrated clinical, payment claims, and population health data enables performance improvement and; consumers' ability to message their providers and care team members and more readily access information relevant to them results in a connected delivery of care that is consumer driven.

We hypothesize that better decisions about health and well-being are possible when consumers, payers and providers have easy access to integrated clinical, payment claims, and population health data, and focus on transforming data into actionable information and knowledge. Consequently, the uptake of these standards-based technologies will lead to improvements in Connecticut's health outcomes, consumer care experience, and reduced cost of care.

To achieve the full potential of the AMH transformation, Connecticut payers and providers will need to deploy a wide range of HIT capabilities. These include payer analytics, consumer and provider portals, clinical healthcare information exchanges and provider-consumer care management tools. Despite Connecticut payers and large providers already establishing significant capabilities, such as, advanced payer analytics and experience with medical home pilots, obstacles remain. Smaller providers face technical challenges and the state's Health Information Exchange (HIE) and APCD are in the early stages of development. Our Innovation Plan proposes the following strategies to advance CT's HIT infrastructure:

- **Enhance payer analytics**
- **Strengthen consumer-provider-payer connectivity**
- **Promote provider-consumer care management tools**
- **Expand provider-provider connectivity**

4.1 PAYER ANALYTICS

We will leverage, expand, and advance analytics to enable health risk stratification, the conduct of basic population analyses, and gaps and alerts. Payer analytics include tools that payers use to analyze claims data; these analyses then produce metrics that assess outcomes, quality and cost and can affect providers' reimbursement. Examples of payer analytics include

risk stratification, quality metric and total cost of care calculations and consumer attribution. Provider tools that use clinical data to assess population risk and identify care opportunities, such as, prostate screenings, can complement these analytics.

The timeline for payer analytics follows the overall HIT timeline; it starts by leveraging existing tools and then implements new ones as they become available. Initially, payer analytic tools will be standardized across payers but not consolidated. Payers will generate highly standardized metrics, analytics and reports, although their infrastructure will remain independent. Payers will capitalize on existing population health analytics while they establish the full set of tools required to support shared savings accountability among providers.

Although payer specific tools enable promising capabilities, these methods are limited in as much they offer a payer specific view. In parallel with these payer led efforts, the state will implement the APCD and begin the development of an integrated data warehouse or registries that can generate information, alerts, and reminders as needed by providers to improve their compliance with guideline-based care protocols, especially for chronic conditions like, asthma, diabetes, obesity, tobacco use, and sickle-cell, which are the focus of the Advanced Medical Home. Everyone engaged in the health care system, including payers, are expected to make relevant data available for population-based analytics, either directly or through the APCD. These analytics will help in the identification of consumer groups that can benefit from increased care coordination.

Currently, there are large differences in the ability of small versus large provider groups to produce and/or consume data in a way that impacts practice. Our proposed solution does not take away anyone's capability but provides enhanced ability to access data and information for both large and small providers. For example, providers can use the results/alerts generated from the integrated data warehouse or registries to identify occasions for care interventions, e.g., vaccination reminders and follow-up activities. Additionally, if resources permit, they can analyze their effectiveness with various sub-populations and use this information to support continuous quality improvement. While payer specific analytic capabilities will remain, the State's investment in integrated, cross-payer data analytic functionality will provide an additional resource to providers, researchers, and policy makers.

During Stage One (Year One), payers will standardize provider reporting based on core analytics, e.g., consumer attribution, risk stratification, risk adjusted cost comparison, quality and utilization metrics; the State will complete the implementation of the APCD; and planning will be completed for the integrated data warehouse. In Stage Two (Years Two to Three), we will implement enhanced analytics, e.g., care gaps analyses, alert generation that identify high-priority consumers who need targeted intervention, implement analytics that identify health disparities, and begin development of the integrated data warehouse. During Stage Three (Three+ Years), we will integrate public health and clinical data analytics so providers have more meaningful performance information and consumers possess a more comprehensive view of their care and implement aggregate analytics and cross-payer provider scorecards by means of the integrated data warehouse.

4.2 CONSUMER-PROVIDER-PAYER CONNECTIVITY

Our HIT strategy will work toward the development of a single provider portal to simplify connectivity to payer data and analytics, and to provide access to statewide data and analytics. Many providers have access now to payer-based portals that connect the providers with health plans and practice management systems; however, there is a need for a single provider portal for use across multiple payers to support access to the payer-provider analytics described above.

Our plan also seeks to enhance consumer access to a consolidated personal health record and decision support information through a single portal. As of January 2014, most certified EHRs have to be able to provide direct messaging capabilities to maintain their certification. The increased uptake of personal health records coupled with the enhanced ability for patients to message their providers and care team members will increase access to healthcare information, services, and communication, resulting in a connected delivery of care that is consumer-driven. Consumers will also be able to use these tools to interact with members of their care team as they review their medical information, care plans and any other recommendations based on their unique needs

In Stage One (Year One) payers and the state will collaborate to develop a multi-payer online portal for providers that will receive static reports or provide access to individual payer portals through a federated log-in. As referenced earlier, Connecticut is also developing an Enterprise Master Patient Index (EMPI) and an Eligibility Management System (EMS), both of which will help link and coordinate the different state health and human services agencies. A consent management process and system will be linked to the EMPI which providers will be able to query. In Stage Two (Years Two to Three), the State will examine the feasibility of a provider portal that allows bi-directional communication between payers and providers as well as data visualization tools. In Stage Three (Three+ years) a fully functional HIE and APCD will enable the development of solutions that provide consumer-provider-payer connectivity.

4.3 PROVIDER-CONSUMER CARE MANAGEMENT TOOLS

Care management tools will help care teams (physicians, care coordinators) identify care opportunities and prepare for consumer encounters. They will also help the teams implement the most appropriate interventions and better manage follow-up care. Lastly, they will facilitate consumer outreach.

The State will deploy a range of solutions to help all providers build their care management capabilities. In Stage One (Year One), the State will identify the provider workflow changes required to improve care coordination and detail the options and applications for supporting technology. We will also educate consumers on healthy behaviors and how to make high-quality, cost-efficient decisions about their care. To do this, the State will leverage existing infrastructure, payers' proprietary tools, NLM tools, and specialized technology.

Over the longer term (Years Two to Three +), we will provide a minimum set of reports that can be used by providers for effective and efficient care-coordination and patient management.

The minimum set of tools will be available so that no provider feels that they are at a disadvantage in this new services delivery model. At this stage we will also assess the viability of developing the shared-service care management toolkit mentioned earlier.

4.4 PROVIDER-PROVIDER CONNECTIVITY

Provider-provider connectivity is the integrated exchange of clinical data between doctors, hospitals, and other healthcare providers through a secure, electronic network. Secure data exchange is a key enabler of population health management. Direct messaging will promote provider communication across care settings. In the long-term, EHR-based clinical data exchange will ensure that providers can access consumers' past care information, even when consumers visit different sites of care, provided the consumers have consented to sharing their health information with members of the care team.

The state will promote clinical data exchange with a standardized – not consolidated – approach. In Stage One (Year One), the State, via HITE-CT, will promote the direct exchange of information between providers with technologies that are easily scalable, e.g., Direct messaging. For example, DSS is exploring the possibility of processing Admission, Discharge and Transfer (ADT) information from hospitals in real time to ensure that PCPs and care team members are alerted when patients are admitted to and discharged from the hospital setting, so that they can coordinate care delivery and transitions across different settings, e.g. acute vs. primary care settings. The State will also support existing efforts to enable clinical connectivity, accelerate EHR adoption, and promote its frequent use. In the medium term (Years Two to Three); provider groups will align local health information exchanges so the exchanges can work together. Eventually (Years 3+), the State will transition to a clearing house (HIE) model for clinical data exchange.

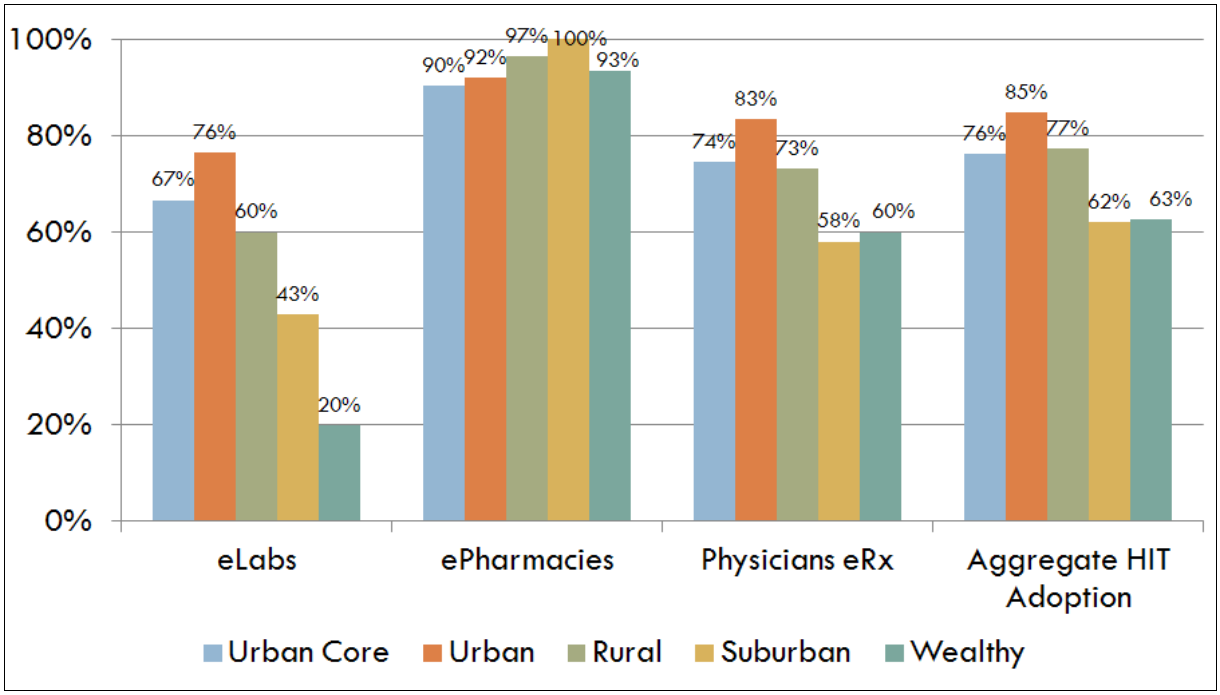
4.5 TARGETED PRACTICE HIT SUPPORTS

Our goal will be to identify gaps in connectivity and work with all providers that are experiencing challenges in adopting technologies and address them as they arise.

For instance, HIT capabilities vary significantly between large and small providers. The State defined a Glide Path for small practices or rural providers who may need transformation support before they can develop the capabilities needed to meet the state's practice accreditation standards and enter into value-based payment.

Furthermore, a recent analysis of HIT adoption data across the state reveals a complicated picture of HIT adoption by town type which may be counter intuitive. We found that physicians in wealthier counties do not meet the EHR incentive thresholds and hence may be on a different timeline for EHR/HIT adoption.

EXHIBIT 21: HIT Adoption by Town Type



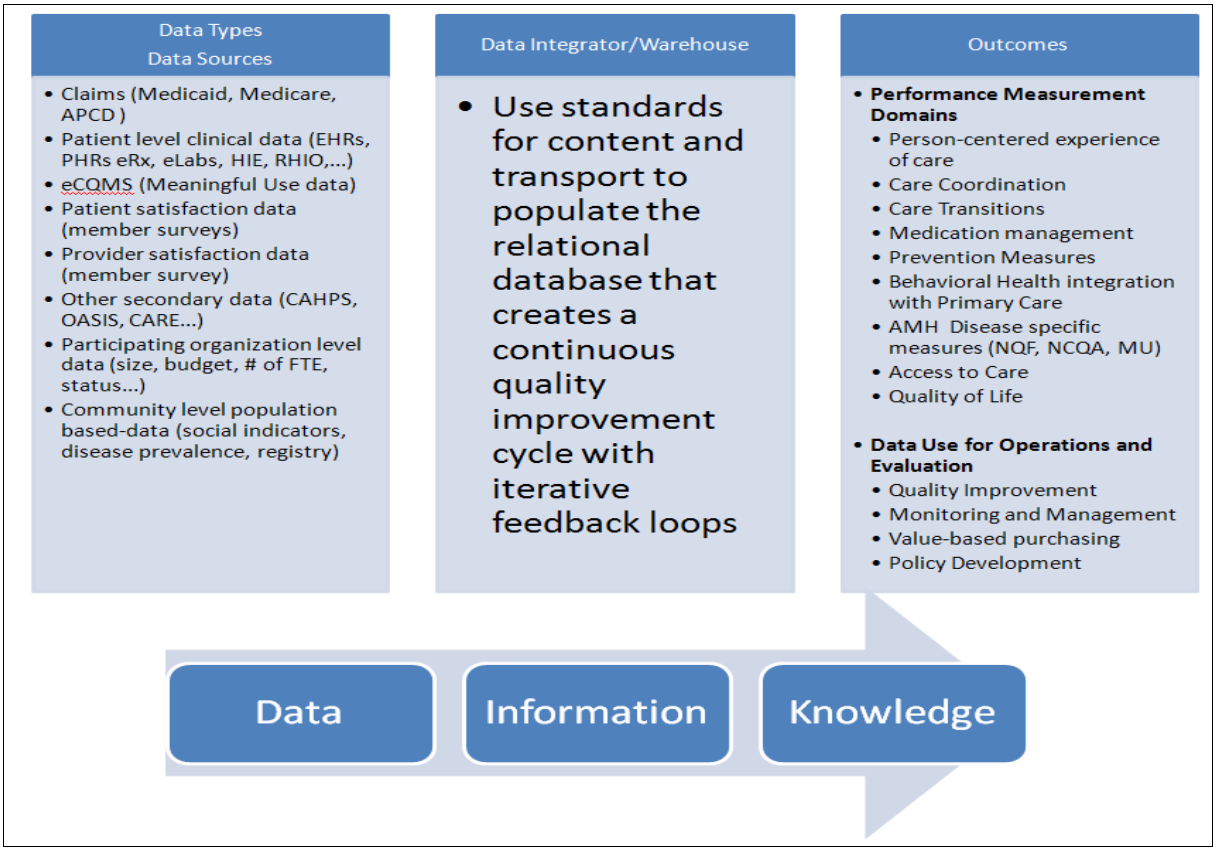
We plan to direct SIM funds to cover some of the gaps in HIT funding

- Connecting HIT infrastructure
- Incentivizing labs and independent pharmacies for adopting standards based HIT
- Incentivize professionals that are unable to access the EHR incentives provided through the HITECH act to adopt HIT tools to be able to interoperate with others

4.6 OVERVIEW AND TIMELINE

Connecticut's overall HIT strategy aims to move the state from integrating and identifying all data that are available to actionable knowledge (Exhibit 22). In the first year, Connecticut will leverage existing stakeholder capabilities as it launches a broad array of fundamental payer-based components. These components will include consumer attribution, risk stratification, performance reporting and specialist and facility analytics. Most importantly during the first year, mechanisms will be identified for bringing disparate data types and sources together including the APCD. If this integration is successful, it will provide the data needed to carry out operations and evaluation over the course of the grant. The State will work toward realizing the goal of one provider portal that provides access to static reports or one step access to individual payer portal, to reduce unnecessary burden for patients and providers. In the second and third years of the project, Connecticut will further develop provider care management tools and dramatically augment the portal and payer analytics, including the introduction of statewide data capabilities.

EXHIBIT 22: Data Integration: data types, data sources, and Outcome



The timeline for Connecticut's HIT strategy sequences the implementation of capabilities according to 1) their value to the AMH model, 2) their current state of development, 3) the time needed to implement them, and 4) their interdependencies with other capabilities (see Exhibit 23). It is not until Stage 3 that we contemplate the integration of public health/epidemic analyses to support our community health improvement goals, including the implementation of Health Enhancement Communities.

EXHIBIT 23: Sequencing for Rolling Out the HIT Strategy