



HIT Policy Committee Accountable Care Workgroup Transcript May 29, 2014

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Accountable Care Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as the meeting is being transcribed and recorded. I'll now take roll. Charles Kennedy?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

I'm here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Charles. Grace Terrell?

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Craig Brammer? David Kendrick? Eun-Shim Nahm? Frank Ross?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Frank.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Yes.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Westley Clark? Hal Baker?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Hal. Heather Jelonek? Irene Koch?

Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Irene. Joe Kimura?

Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Joe. John Pilotte? Karen Bell?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Right here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Karen. Mai Pham? Sam VanNorman? Scott Gottlieb?

Scott Gottlieb, MD – Resident Fellow & Practicing Physician – American Enterprise Institute

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Scott. Shaun Alfreds?

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Shaun. And from ONC do we have Alex Baker?

Alexander Baker – Project Officer, Beacon Community Program - Office of the National Coordinator for Health Information Technology

Yes.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi Alex and is Kelly Cronin on? Are there any other members from ONC on the line? Okay, with that I'll turn it back to you Charles and Grace.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, very good, thanks everyone. Today we have a variety of things on the agenda that we want to talk through with the specific one being a summary of the initial draft set of recommendations that we provided to the HIT Policy Committee on April 8th and then later moving into a discussion about finalizing those recommendations that we will present on July 8th.

In terms of how the recommendations were received by the HIT Policy Committee I think that we were very pleased with the response and with the comments we got from the members of the committee who delved through our presentation, you know, words such as it was complete, it was comprehensive, you got all of the major issues here and your, you know, suggestions and approaches resonated was generally the type of feedback that we received.

So, we felt, and I think all of you should feel, quite good that the document was felt to be high in quality and appropriately summarizing, you know, at an admittedly global level, all of the various challenges that ACO initiatives out there are facing.

With that maybe we can get into some more specific comments that were made, but Grace, I thought I'd turn it over to you if there are any comments you'd like to share about the presentation and how it went?

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

No, I agree with your summary Charles and my general impression is they listened attentively, they asked very good questions that flushed out some of the issues that clearly they had some concerns about to make sure that we address those in ways that were relevant to their overall thinking about the policy and I think as we get more into the document here we'll see some of those specific comments and can flush that out more than just what we're doing right now.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, all right, very good, so some of the areas and I'm on – I don't know if we have the WebEx up but I'm on slide 1, summary of the April 8th HITPC discussion.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Yes.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, some of the specific areas I was particularly pleased with included the fact that there was I think pretty broad recognition that we need to think beyond just the electronic health record as an application and Meaningful Use as a construct and really think about data, data in terms of the need to serve patients, data in terms of the ability to empower physicians.

So, I think that was important because if you'll recall when we started this Workgroup we took the approach – we purposely took a broader approach we did not try to fit kind of Meaningful Use into what ACO needs, what an ACO might need, we purposely took more of a global view that said, you know, what are the technology needs to be successful in accountable care and kind of took our directions from that rather than kind of trying to force it into Meaningful Use and I was very pleased that the members of the committee agreed and endorsed that type of approach.

Some of the concerns that people had are listed on this page, you know, one area that I think got a fair amount of discussion was being cognizant and careful about the level of regulatory burden, you know, we might think something is a good idea and might have broad applicability across ACOs, but I think, you know, we've been concerned as we've created our workshop or subgroup process and the members also echoed that, that we're not putting so many regulatory requirements in the way that we might, you know, further kind of tarnish or inhibit the ability of ACOs to get support for the kinds of technologies they need to be successful.

In terms of privacy issues and data, you know, many times you are in an ACO bringing together hospitals and doctors who may not have much clinical or affiliation, in other words they might not be employed by a single entity you might be bringing a lot of covered entities together.

This is one of the areas we didn't really spend a lot of time on is the privacy issues associated with integrating perhaps claim data from a payer, clinical data from a physician, personal input data from the patient and how all of that gets, you know, sorted through from a HIPAA and privacy perspective. And so that was one area I think that, you know, they asked a lot of questions on and I think in our deliberations just hasn't been an area we've been focused on.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

And Charles, I might add that there was a fair amount of, I thought, passion about this issue which some of the committee who felt very strongly that it needed to be prioritized. As we move forward we need to think through the importance to those that are accountable for care of having access to information as it's going to relate to clearly the concern that was there for privacy.

And it may end up being a point of, if not tension or conflict, at least something that's going to bear some very, very important need for critical parsing of how that's going to be put together when it comes to policy, because clearly there is a potential for conflict if it's not done appropriately.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yes, I think that's right and I think, you know, we had kind of purposely, you know, kind of not focused on privacy as a part of our activities because there is a, you know, a whole Privacy Workgroup that is taking on these types of issues, but I think the fact that it was brought up and as you said, Grace, with quite a bit of passion means we may want to be, you know, cognizant of that in our final recommendations.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Yes, I agree.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

In terms of – that was really kind of at a high level what we experienced just very supportive and very receptive to the work output we had so far. Before we get into today's review I don't know if there is anyone else on the Workgroup who either happened to participate in that meeting or had any questions or comments about how that meeting went or other areas you'd like us to specifically comment on?

Okay, well, then let's move into today's review and in today's review we're really trying to so to speak, bring this work home, and prepare for our final recommendations that will reflect this work stream. And we've got a series of focus areas – two that, you know, really have a background with the rationale for talking about this area as part of an ACO. What are we saying, what are the themes that are, the strategic themes around a particular work area and then what are our recommendations associated with that.

And so, moving onto the third slide, the purpose of our discussion today, you know, do the areas we called out as areas of focus make sense? Do we want to have any changes or editions or do people have any particular strong reactions to the strategy statements and priority recommendations? And so that's really the purpose of today's call.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

The on line slides are not progressing.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yeah, can we go ahead one?

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

There.

Caitlin Collins – Project Coordinator – Altarum Institute

Not a problem. Please just say “next slide” and we will take care of it not a problem.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, so if we could move to slide 4, final recommendation focus areas. And as you see on slide 4 we have 5 focus areas and then we’re going to get into the strategy statements, the priority recommendations on an area by area basis.

So, moving now to slide 5, and looking at exchanging data across the healthcare community with a specific ACO focus in mind, I’m not going to read through the strategy statement I’ll let you all just read through it. Again, slide 5 and the four items there.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Charles, Charles?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

This is Karen Bell, I’m wondering if we could go back one to the 5 different focus areas for just a moment?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Sure.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

And I’d like to preface my comments about the fact that this is just – I love the way this has been organized in terms of focus areas and then the strategy statements and the recommendations and I can’t thank the ONC team enough for pulling this together in such a cohesive and clear way.

What I’d like to do though is comment on those 5 strategies, because they’ve changed a little bit over time and I’m wondering about the first one being more about sharing information and exchanging data points because data points, as they get exchanged, requires a portability and we’re going to be talking about that in the second one, but there is a lot of information – well, first off big difference between data and information.

And there’s a lot of information that’s out there that could be shared and all of our recommendations and our strategy statements would be referable to sharing information beyond discrete data points.

So, I’m wondering if we might want to change, I just want to throw out there, the possibility of changing that description just a little bit to focus on the sharing of information rather than confuse that with data portability which is the second one.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Karen, this is Grace, if you go to the next slide, I had a probably parallel thought process, you got much better at the context then I did between data and information, but in the first strategy statement where it basically says, sharing information, which is of course what we’re talking about broadly, it said with partners to improve the quality and safety of care across settings.

I’m actually worried about the word “partners” and the reason I’m worried about that is because from a patient-centered stand-point it should not just be about those that are strategically aligned in some sort of partnership if that –

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Right.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

But it should be anybody out there that has appropriate, you know, privacy related permission that has an impact on a patient's care and one of the things we heard at the hearing was, you know, the concern about information hoarding.

So, I think this first statement here is consistent with your concerns that sharing information rather than data is – which is actually said here, maybe a better way of prioritizing that.

But, again, sharing and information should be from a patient-centered stand-point not from a strategically aligned partnership stand-point and I apologize for only coming up with these comments now, but it didn't strike me until I was looking at it again last night.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

That was my problem too Grace and again it's just a matter of perhaps clarifying those focus statements a little bit more and, as you say, sharing information in a patient focused way or a person centric way across the healthcare community. I think that really drives the focus home to what we mean in the background strategy statements and recommendations for that first one.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Hi, this is Frank; I'd like to just recommend that in the first focus statement that we do change that from data to information, because I think you're absolutely right about that.

And in the first bullet point on the strategies if we just change the word "partners" to say are sharing information broadly between healthcare providers to improve I think that would be a much appropriate statement.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

And then I had one other –

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

I had one other comment on the focus areas as well and it's number three. It's scaling the data infrastructure for value-based programs is clear to you and me, and everybody in our group because we've been talking about this for over a year, I'm wondering if would be clearer to everyone else who picks this up and reads this if it were to talk more about leveraging the existing data infrastructure because everything we talked about that was included in that was around data that already exists but isn't made available or used widely whether it was ADT information, whether it was the social determinants of health, whether it was claims or encounter data. All of that exists in electronic format but isn't made available to the ACOs. So, to me it's more about leveraging existing data in a way that it can be of value to these programs.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Well, I think that's fair Karen, I guess the question would be although those data sets exist in whatever repository they are currently in they frequently aren't made available for sharing and I think, for value-based programs, I think what we were implying there was, as you mentioned ADT, maybe encounter data from a health plan, etcetera and making all that available through a data sharing infrastructure.

I think, you know, the HIEs I'm aware of don't frequently exchange the claim data and so I'm not sure – I'm sorry, so what was your recommendation there? How were you thinking about changing it?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

I was basically thinking about just changing it to leveraging existing data infrastructures for value-based programs and then a recommendation would go into, including all of those and maybe I've just missed it, I've read these things a couple of times and it's been a busy time, so maybe I missed the recommendation we had about, you know, scaling ADT feeds. But, I didn't see it on the document anywhere.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

I think, in that one I think what we were talking about, and again, you know, others feel free to chime was when you think about the data infrastructure for value-based programs I think what we were trying to signal there was that the data infrastructure required might need to be a little bit more broad than just an HIE that, you know, generally has clinical data and doesn't have claims in it.

So, you I think associated that we made a recommendation for, you know, all payer claim databases and just better and easier ways to make the claim data which can be, you know, critically important to an ACO maybe not as important in a fee-for-service world more available.

And so in many states I think we were trying to make the point that there aren't all payer claim databases, there isn't necessarily a data sharing infrastructure to allow, in the case of claim data, you know, easy access to all of that and there is not even, you know, real clarity on how to use the claim data appropriately in clinical settings.

So, I think that's why we were saying kind of instead of leveraging the existing kind of, yes that's true, but also promoting kind of the creation of new infrastructure that would make it easier to facilitate things like claim data sharing.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Absolutely, and I couldn't agree with you more Charles and maybe this would be leveraging existing data sources as opposed to infrastructure because it went far beyond claims.

Again, we had talked about ADT feeds we had talked about social determinants of health and encounter data. So, there were a number of other currently existing data sources not necessarily infrastructure like an ABCD that can provide an opinion but data sources that could be made available to ACOs in such a way to make them more productive, help them meet their goals.

And I just get – I was just feeling a little bit like we were losing the emphasis on the ADT feeds, which we had talked about, and even when we come to social determinants of health it's more about making that data available period not necessarily exchanging it and, you know, it's great if we can support the HIEs going forward, but I think we have to find some way to at least free the data to use one of Farzad's old comments, because right now it is locked up in a number of sources.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah, okay, fair enough. Other comments on that?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Yeah, this is Frank, I think we're talking about two semantical issues that aren't the same, you know, I interpret scaling as giving me access to.

I interpret leveraging as being able to utilize information I already have access to. I don't know if that helps this conversation any, but that's how I view those two concepts.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Great, yeah, no that's helpful. Other comments? Okay, so Karen you want to – so if you could restate, you want to rename number three as leveraging existing data sources?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Or going to Frank's comment, something about increasing access to existing data sources important for value-based programs.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Got it, okay, very good.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Thank you.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Shall we move onto slide 5? So, topic area one, exchanging data across the healthcare community. I won't read through the strategy statements I just ask for you to look at it on the screen. Any comments from people?

Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.

Charles, this is Irene Koch, maybe in the second strategy statement to the extent that we might have under represented concerns about privacy, which admittedly were in a focus, so much of a focus of the testimony in our discussion but certainly were underlying – an underlying concern of everyone, maybe we could expand that statement across different policy levers and be a little bit more specific about needing to clarify some privacy and data sharing issues about consent and otherwise there.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay. Others?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

This is Frank again, in that second comment as well, you know, if you work in an ACO, particularly since last September with the new requirements and you're talking with lawyers writing contracts you've discovered that there is a real nightmare out there right now because the whole legal profession is trying to – well they're trying to start a second retirement fund off of the changes.

And one of the things that comes up consistently is that there is an impression, in the legal community today, that all bets are off because of the new regulations and if you do not re-engineer your agreements, your HIPAA agreements, your BAAs and your DUAs then you are technically in violation of the law.

So, what I'd like to suggest is that HHS should promote universally consistent requirements that can be easily ascertained by any participants because right now it's gotten from really bad to really worse than it was before last September.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Great, okay.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Yeah, I agree with that Frank, thank you, this is Karen.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, any other comments, concerns, clarifications on slide 5? Okay, so we'll move into the recommendations on slide 6. We have two recommendations, priority recommendations, I won't read those I'll just ask you to take a look at those and offer any comments.

By the way before I do that does everyone on the line – does anyone on the line not have access to either the PowerPoint or the webcast, anyone working from just a phone? Okay, good, so you can all see it. Okay, so any comments on 6, going once, going twice?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

This is Karen Bell again, I think this is section (e) this is where we had the social determinants, but again everything else under this area is around encouraging the sharing of information and (e) is actually about providing access to data. So, I'm wondering if this doesn't belong under focus 3.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

This is Hal Baker my only question on (a) is whether the bolded section, talking about discharge summaries, in any way takes away from the last sentence talking about notification of admission which is another important time.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

So, maybe expand – you're suggesting maybe expand the bold section to include kind of admission, discharge and transfer information inclusive of summaries something like that?

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Something like that, it could certainly be just the ADT feeds which sounded quite powerful during our testimony.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yes.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

That was relatively low hanging fruit.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, okay we've got that.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Yeah and my thought was, this is Karen again, my thought is that it would be important to make that a separate recommendation for the reasons that Hal just articulated what's pulled out on a number of occasions as being a very specific thing that needs to either be scaled or be made available.

So, I think it should be a separate recommendation and it doesn't matter to me where it goes either under here or under 3 but that is information that's already electronically available and we need to free it.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

Hi, this is Shaun Alfreds, I would agree with Karen's comment it seems like we're putting too much into (a) here because we've got the survey and the survey should give guidance on assessing the degree to which hospitals are sending electronic discharge summaries and then we talk about ADT. I think we need to separate those to be more clear.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I support that, this is Hal.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay, we've got that, very good. Any other comments on slide 6 specifically around the transparency recommendation?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Hi this is Frank again, with Stage 2 on the skids again and Stage 3 still hanging is this statement even technically correct any longer?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah, should we say potentially aligned with – let's see.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

I'm having a hard time trying to piece together the right verbiage to describe what's taking place right now.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

And until we get a final decision from – you know, regarding the Stage 2 options they're still kind of up in the air. It's a confusing statement the way it's quoted right now though.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

So, should we just get rid of the part in the parenthesis and maybe put something about align with Meaningful Use –

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Objectives – moving forward or something like that because I've got a sneaking suspicion that we're going to wake up one morning and in the middle section of the Wall Street Times it's going to tell us that the whole thing has been redone. So, I don't know.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah, okay, let's move on.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

I think –

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

I'm sorry someone was talking please go ahead?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

No, this is Karen, I said that's sort of what happened with ICD-10, but, you know, I understand what you're saying Frank.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

To be honest with you, again, as a boots on the ground ACO, we use the term Meaningful Use when we talk to hospitals and we get big yawns. So, I'm not even sure that's on their radar screen quite frankly. And maybe it should be, maybe this statement would be better worded and Alex I don't know how to give you guidance on that but, you know, the fact that hospitals are pretty much taking a pass on Meaningful Use except where they feel that they can leverage the revenue from it because there is no Meaningful Use from the perspective that we're trying to promote it and that is sharing of information.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yeah, I think, you know, for this one we're not necessarily tied to the Meaningful Use measure but, you know, we're casting about for if we wanted to do this transparency piece what is some measure that we could reference to measure transitions that could be put in here and that's sort of the closest thing available.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

I guess I'm trying to say I'm not – and maybe there will be some disagreement on this, but I'm not sure we need to hitch our wagon to Meaningful Use regarding hospitals. Because, I think we've got to press forward on the initiatives that we've identified, you know, ADT just being one of the highest priority ones, but we obviously need more than just ADT.

We need to get the various components of Meaningful Use when it comes to exchange of information that has been around for quite a while and has been blatantly ignored and if we keep waiting on Meaningful Use it's just not going to happen.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

And this is Shaun Alfreds and looking at Meaningful Use in general, you know, maybe I'm the only one that's going to admit this, but I think the Meaningful Use transitions of care measures are woefully designed in the wrong direction.

I don't think that those measures when operationalized actively promote health information exchange. I can say, certainly in our state that it's just the opposite.

We haven't seen the Stage 3 measure yet final, but I'm very concerned about us taking the track of hanging our hats on a policy that has shown that it's not as meaningful when implemented and rather than focusing on very concrete, very specific strategies that can be operationalized for ACOs.

Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, Shaun and Frank, this is Kelly, I hear what you're saying and I think we're really, at least internally, we're really aware of the shortcomings of the ToC measure and it's unfortunate that that's what the current law is in some ways.

But we do have an opportunity to get it right for Stage 3 and I think there is a lot of active consideration about how to do that and that's a couple of years off. But, in lieu of that I think there is also, you know, a need that just to try to sort of fulfill the National Quality Strategy they're trying to address a lot more care coordination measures and as part of that they want to have a good, you know, measure of exchange.

So, I think there's probably more, you know, a couple of different opportunities for us to get a good measure of information sharing that supports transitions of care and we'll just look for the best way to do that we just have to make sure it's operational and something that we can actually get good data on. But we totally understand the limitations of tying this strictly to how it's defined in Stage 2 Meaningful Use.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Hi, sorry, this is Charles, I was disconnected. Where are we now in the conversation?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

We're still talking –

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

We're still talking about (b) the transparency item and the question of whether – what appropriate measure we could reference here given some of the issues with Meaningful Use Stage 2 transitions of care.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Got it.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

We've probably beat the horse to death anyway, so why don't we move onto the next portion if there is consensus with that.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay. All right onto slide 7. The two recommendations here provide additional shared saving incentives to ACOs that include partners who are not eligible for EHR incentives. So, this is a nod to the importance of long-term and post-acute care providers, behavioral health providers, home health providers who have a critical role in reducing unnecessary re-admissions, coordinating care, etcetera. So, this is a call for finding ways to make sure that they become part of the incentive process to become electronic.

And then the second issue, issue additional guidance around sharing of information protected under 42 CFR Part 2 across participants in an ACO. So any comments on these two?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

This is Karen, Karen Bell, on the 42 CFR I don't know if everyone else saw that on the 11th of June you can register for a conference where SAMHSA is looking for some public input on exactly this problem. If you haven't signed up it's still available. I will be joining that call.

But, yeah, I think it would be – I think this is a very important recommendation as it's written because at least it can add to the conversation that obviously SAMHSA has started and being able to articulate the fact that at least guidance would be helpful even if they can't change 42 CFR for another few years would be helpful.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Great.

Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.

This is Irene, yeah, Karen I'm going to be on that call as well and I'm just wondering though, I certainly don't want to dilute this recommendation but just apropos of the points that we were talking about before there being additional privacy and legal issue concerns, I'm wondering if there is an easy way to expand this to suggest that we need guidance about data sharing across organizations and legal structure of agreements in general not just for SAMHSA. And maybe this would be a good place to put it.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

That would make it –

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

So, how are you proposing we change it? Could you help me a little bit with the wording?

Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.

Yes, so maybe instead of just saying, issue additional guidance around sharing of information protected by 42 CFR maybe we say, sharing of information across provider organizations including but not limited to 42 CFR.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Okay.

Irene Koch, JD – Executive Vice President & General Counsel – Healthix, Inc.

Just add, you know, another sentence in the beginning about general guidance, because certainly in the testimony we did hear an underlying concern about privacy when we asked but it wasn't sort of top of mind I don't think as the first concern but it certainly was in there.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yes, very good, other comments? Okay, shall we move onto slide 8? All right, slide 8 the priority recommendation is a nod toward the importance of, you know, non-traditional or non-core clinical data elements and trying to make sure we capture more broadly things like the social determinants of healthcare that can be very important to an ACO. So, again, I'll leave you to read through the text. Any comments on this particular recommendation?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Charles, this is Karen, I'm sorry, I jumped the gun on that, I don't have the slide set in front of me I just have the document itself, so this is the one that I thought might go over to focus number three.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yes, got it. Okay with that I think we can wrap up our first area and move onto this next focus area which is data portability for accountable care. Karen do you want to drive any of these? Karen, I'm sorry, Grace.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Sorry.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

I'll be happy to drive you've been driving for a while here. So, just again I think the way you're doing this is correct which is not to sit here and read statements but to have the slides in front for comment. We've already talked about differences between data and information. Any comments from the strategy statement stand-point that needs clarification here?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

This is Frank again, I hate to bring up Meaningful Use Stage 2 but, you know, we've leaned on that pretty heavy as a crutch in the background statement for this. I mean, we're not looking at that on the slide, but –

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Right, you're right your point about standards and certification clearly is pointing to that. Would it be reasonable to, rather than future certification standards add an adjective such as "all" or "any" or "probable" or "possible" in front of that which would make that less worrisome for you?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

I think it would be a thumb in the eye of the folks that need to have a thumb in their eye about, you know, the fact that it doesn't help us formulate policy –

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Yes.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

If these initiatives get stalled, okay, so I agree, yes I do Grace, I think it needs to be pointed out.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Okay.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Yeah.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Other comments? Well, let's move onto slide number 10 then so that we can get into any of the specific recommendations and any comments people have on that.

So, I'll take Charles's lead and not read to you since we all have that capacity since it's in front of us and ask if there are any specific comments related to slide 10 with the priority recommendations?

Well, you know, Charles, clearly I needed to be the one driving the car because everybody is scared fearless and won't say anything.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Wait until the next one comes up.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

All right, well –

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Grace, you did beat the crap out of this many times before so.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Yeah.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

So, let's move then so that we can go through all this, if we could go to the next slide if anybody has no specific objections about strengthening the data portability elements, any comments here?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

I think this is really well done and I have no comment on it, thank you.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Excellent work.

Shaun T. Alfreds, MBA, CPHIT – Chief Operating Officer – HealthInfoNet

This is great.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I guess the only question would be, is there any point of it being (a) versus (c). Everybody can publish but nobody can ingest and that's a great quandary, this is Hal again. I don't know if it matters, the lettering.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

I get gaseous just reading it, so I think I understand what you're saying. The receive and process I think would –

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yes, ingest I guess, right, maybe not the best computer word.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Metaphors are kind of thick, yeah.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yeah.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Well, let's go onto the next slide and let the wordsmiths fix some things. So, I think we're to the third set right now which is scaling the data infrastructure for value-based programs. There is one strategy statement there before we get into the details. Let's stop and see if there are comments here.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

I'd only say that this really does capture the concept of all administrative and accountive data and maybe we just, you know – residing, currently residing, because I think it is about that existing data that we can't get to.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Good point so you were suggesting adding the word "currently."

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Yes, that's all.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Excellent. Other thoughts? Well, let's move on and get to the specifics. So, the next slide has a recommendation (a).

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Well, this is Karen, I'm jumping in again, before we can think about integrating claims and clinical data maybe we should think about integrating claims from multiple payers first because so many of the ACOs do have multiple payers. So, maybe the first recommendation should be around encouraging the all payer claims databases.

And then this brings up the discussion again about whether or not we want to include a recommendation on the ADT feeds here because that is existing data whether we want to include the recommendation on the social determinants of health here.

And then, ultimately, at the end put the two recommendations on how you might use some of this, because, you know, the attributions, the common way of doing attribution really falls under administrative simplification more than anything else but that's how you would use the existing data that you can get to.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Hi, this is Frank, one comment, I understand the concept of all claims databases, big data, but I think the reality is that again, boots on the ground, as an ACO we're integrating claims already from commercial and CMS into a single registry management and quite honestly we didn't have to debate it very long to launch into that initiative because the commercial payers are knocking our door down wanting to give it to us and CMS has finally given it to us because we are an ACO and without integration today we can't make progress.

So I'm not sure – I guess what I'm trying to say is I'm not sure that it's going to be highly speculative on our part to assume that there be a model moving forward for big data when we talk about claims databases and I'm not privy to all the other initiatives, I wouldn't begin to talk to that. But I do know that I think it's a great idea that's probably never going to happen in a competitive market anyway.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Well, the only – I think the reason that we had it here Frank is that there are already 13 states doing this and another 6 or 7 moving in that direction, and it is a huge economy of scale for the ACOs in those states because it's already done for them, it's done at the state level and the state can regulate that all payers join it. I mean, that's in their discretion to do it. So, it is taken entirely out of the hands of the physician community but the data can be made available to them in a much less costly end and with a lot less hassle.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Can I clarify; are we talking about 3(a) or 3(b)?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

That one was 3(b).

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

B.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Okay.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

And my only point around that is that if you start with – you know you have to have the integrated claims pretty much before you think about integrating the claims in the clinical unless you're only dealing with one payer.

But so many of them are dealing with multiple payers now that it seems, again, like it would be more helpful from an economy of scale point-of-view to be able to start with the claims first and then add the clinical.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

We're actually doing it like the opposite, the claims data subordinate to our clinical data, because we look at it more as a patient-centered registry approach.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

It has a very different use.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Yes.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

You know obviously you need the clinical data for anything clinical but the claims will help you manage your finances, which is going to be critical as well if you take on increasing risk.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Well, and also it will help you identify practice patterns that will hurt your ACO if not corrected such as, you know, patient leakage or some people use the term patient keepage, but referral patterns, all those kinds of analysis can be helpfully supported through claims data.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Yeah, I would say that the clinical data absolutely Frank is priority and crucial but at least for our ACO and particularly with the current attribution issues having access to the overall global cost of care is not really possible without access to claims from other sources of care and again identified patterns of utilization we would have no ability, particularly in our Medicare Shared Savings Program, based on our clinical data alone. But you're right, that should be where we all start in the world that we hope to get to one of these days maybe we'll be there.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

So, this is Hal, am I reading correctly that 3(a) is about the need for clinical data to manage clinical outcomes, 3(b) is about financial management of accountable populations?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Nice way to put it. I think that's right Hal.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Yes, that's well said.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yes.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Well said.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology a

And we can already – (b) is already being done in multiple places, (a) is still in development.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Let's move onto the next. So, we're now to the next section which is IV clinical use of data and information to improve care with the strategy statements listed. Comments? Okay, move on. Next slide.

So, here we are the priority recommendations again, we've got (a) and (b) there accelerate the development of adoption of standards-based shared care plans and develop pilots to test different shared care plan models.

I want to stop here and maybe just comment that in the hearing there was some concern that was stated that sort of crossed professional understandings of care plans was not apparent in our original discussions and recommendations, specifically, this was a nurse who was speaking and talking about the fact that there is already expertise in care plans from a nursing perspective.

What we had in discussion after that was some discussion as to whether care plans from a single discipline as was talked about within the hearing versus and overall understanding of care plans that would work across the spectrum was maybe a slightly different conversation.

So, as we're looking at the recommendations here I just want to make sure that the language sort of meets both the criticisms that we heard or the feedback I should say as well as our thought process about how that might make a difference across the spectrum of care.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

I think there is a difference between the shared care plans as thought of from a nursing perspective where it's shared with multiple disciplines from a hospital perspective but not usually actively involving contributions from the patient or family that a shared care plan is discussed in the medical home where it absolutely requires shared contributions from the family and patient but I think the words are used with slightly different meanings inpatient and outpatient and I worry that may be confusing. Maybe other people haven't had that experience.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Is there something that we can do, an adjective or some other clarifying statement that we could make to emphasize your point because I do think that there is some rationale need to make sure that we understand that if we're going to use and discuss care plans exactly the fact that different settings have different thought processes.

We talk about, in this guideline, you know, pilots, we talk about initiatives to sort of understand how it might be done, but does there need to be any flushing out of the concept of care plans as defined that would work or focus across the spectrums of care?

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Grace this is Karen, maybe just in the very first sentence when we talk about building on existing standards we could talk about existing experience or current experience and existing standards, and then later on in the sentence pull in the points that you've just talked about shared, you can call it dynamic shared care planning across the full spectrum of care.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

That's a nice way of putting it.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Grace, somehow we've got to get across that this is intermural between organizations differentiating it from the intramural interdisciplinary plan of care that a lot of nursing programs are working on, mine included, to bring the different care teams together in the hospital for a single care plan during the hospital stay.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

This is Frank; this is one of the most difficult sentences I've ever tried to digest and I've got colon, semi-colon, slashes it goes on and on, and that's not a criticism but I think it was an attempt to wrap up an entire – in one sentence.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Frank you'll be happy to know that –

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

And quite honestly it, you know, the meat of the problem is that you've got so many care settings that have their own dedicated care plan methodology and we haven't even scratched the surface on it as a regulatory process and I just want to point that out that maybe we're trying to say too much in one sentence.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Frank, I was going to say, you'll be happy to know that this sentence was created by another committee for this committee.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Alex, I didn't accuse you of it.

Alexander Baker – Project Officer, Beacon Community Program – Office of the National Coordinator for Health Information Technology

Yeah, that's –

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Well, perhaps we can sign on as Hemingway or somebody to make these sentences parse a little more succinctly to get our plans across.

I like your intramural versus intermural metaphor and, you know, another way of just maybe talking about that is across the spectrums of care or something like that, but anyway, I'm going to keep us moving unless anybody has an objection let's go to the next slide.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

The only – Grace one last thought, perhaps shared care plan needs a definition for the purposes of this even if it's an appendice an appendix or something, just defining how we're using it and that can be done off line.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Okay, great, thank you. Comments on the next one?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

I'm glad to see the CDS survived it's critical.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

So, we're now on slide 18, which is the final category of streamlining the administration of value-based programs and Frank I think very much this has been something that you've been championing throughout your contributions on the team and I clearly agree with you being in the trenches with you on much of this. So, I'm going to stop, we've got our strategy statements there and see if you or any of the other folks want to make some comments on this?

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

The thing that I don't see in the strategy statements was something that I hoped I had communicated effectively and that was that ACOs, particularly ACOs that are of the venue that mine is, which is a group of very loosely federated independent primary care physicians in rural settings just do not have the financial means to maintain an ACO as an organization unless there is a funding mechanism in place and I think I pointed this out before, but I'll say it again, that current contracting that we have, you know, the checkbook stops writing at the end of this month and now we're trying to figure out how to sandbag to survive the next two years.

And that all said and done if we could add something where we say HHS should continue to explore ways to accelerate toward the vision of standardizing all measures, yada, yada, I mean those are great comments but at the same time we have to put something in here in the strategy that says to ensure that adequate funding is in place for continuity.

Because you're going to lose a lot of ACOs at this first round. They're not going to be around because they're just not going to be financially in a situation, considering the number that actually achieved pay out they're just not going to be in the shape to move forward.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Frank, this is Karen, Frank is part of – could part of that be because they didn't have the appropriate readiness to start taking on risk and become an ACO, they didn't have electronic health records across the board or a number of other infrastructure things in place to support taking on risk of some sort or taking on shared savings?

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

It gets to cost Karen.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

If you're saying maybe they weren't prepared, of course they weren't prepared nobody had a clue as to what this was all about. If you go back to the original application process there was nothing in there that enlightened anyone as to what they were going to be facing. So, but Grace you wanted to say something?

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

I apologize for interrupting you, but from our stand-point Karen I think that my organization had already made the decision to move forward with accountable care and value-based contracts as our, you know, strategic direction.

The cost of the infrastructure for any ACO has to be borne up front and the process of actually getting any return on that comes downstream.

So, I don't know that it's so much a question of readiness, because I would say that we certainly had done so as it is a question of cash flow particularly for some of the physician groups who might not have a hospital type of a balance sheet to move forward with it.

So, this goes back to one of the previous, you know, categories on up front funding, but that's part of it. You know as you're dealing with administrative complexity it requires resource.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Absolutely and the only reason I was bringing that up is that there are two ways you can do this, you just make more money available or you tie that money to at least a set of requirements or something like that to demonstrate that you are then ready to move forward and will use the money or can use the money in such a way that you will get to your goal so that was the only reason I brought that up.

Because I think Frank you're absolutely right, most of the organizations that got into this didn't quite realize and never had experience with risk before, didn't understand the importance of the information necessary either clinical or administrative and many, as we heard from our own December meeting, had no idea – right now have no idea whether they're making or losing money and that's not a good place to be.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

And I'm not trying to be adversarial about the contractual process even though it really wasn't a process it was take it or leave it, but it wasn't structured in a manner that is consistent with what the commercial payers are offering for sure.

And something just as simple as an advance payment for seed money, if you want to think of it as a startup, and then at least a consistent monthly PMPM to cover the administrative cost of both implementing and maintaining population management, that just makes a lot more sense.

And, you know, I read through these and by the way there is nothing in here in these recommendations that I'm opposed to, but I just don't hear the echo of what I just said in here though, I just don't see it.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

How would you –

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yeah, Frank, this is Charles, I think that's a fair point but I think listening to this discussion I heard two themes, right, one was a theme associated with finances and I think what I heard and I agree with is not only are you making these folks who are signing up for ACOs take a speculative bet and not only are you requiring them to work for over a year before they know if that speculative bet is paying off, but then when you look at, you know, the savings that result, you know, you've got to absolutely knock it out of the park to get any real and meaningful offset to all of the revenue and associated profit you would lose by treating those people, those Medicare patients, specifically in a fee-for-service way.

So, it sounds like there is kind of two points, right, one is a financial point around the speculative nature of this and the government crafting it in a way that makes it harder and riskier to try and attempt it.

And then I think I heard another point about, you know, readiness and I'm not as clear on that readiness point, but I think I would agree with you very strongly on the financial side.

Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health

So, this is Joe Kimura from Atrius, I think one of the thoughts I have based on what Frank was saying too, is I think part of the infrastructure evolution and the maturation I am wondering if there is some guidance that can be made as these measures are being standardized with respect to some sequencing of how that infrastructure should be matured in accountable care models that could give more guidance and then attaching some of those financial sort of upfront costs more directed towards areas that we know any organizations taking accountability need to have that capability.

So, case in point, examples, people investing a lot of infrastructure IT on sort of managing chronic disease care and not focusing a lot on transitions with ADTs and really understanding that medical expenses from hospital admissions are probably going to deep six you before that diabetic care is going to get better. And again, there is a lot of that which comes forth that's very attractive, so can we provide guidance in terms of how this gets implemented.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Joe, this is Karen, and I think that's what I was talking about readiness it was a little bit about that. We had some discussions a while back about having the program going forward request that applicants really talk about either a glidepath or a roadmap on how they're going to go forward with their HIT, with their programming and a number of other things so that it was very clear that they had thought through the process of which you just have given an excellent example about how they're actually going to move forward to reach their goals, because I think a lot of them didn't really get into that until many of them were actually getting into trouble financially even the pioneer ACOs were – I think several of those were in that ballpark.

Joe Kimura, MD, MPH – Medical Director, Analytics and Reporting Systems – Atrius Health

Absolutely.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Yes, that's right.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

I think the recent Universal American announcement – if you haven't read that you need to read it because they are a significant share of the entire ACO market and they're virtually going to be shutting down half of their ACOs.

And this is something that it resonates with me, you know, because our ACO is a private corporation it's not a non-profit, it's a private corporation and doctors are invested, they're not invested heavily its more sweat equity than anything but as these stories begin to erupt and after the first interim financial reconciliation for the 2012 startups is released, the results, and only 1 out of 64 that fit our model actually achieved shared savings.

And even though we did generate savings because of the, what I call draconian thresholds, 3% that were applied to us, you know, those sort of alignments and boundaries and things like that are so counterproductive when we're talking to commercial payers that essentially measure our success against the market. And we're not getting measured against the market, we're getting measured against ourselves and –

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

The point is well taken, we did not receive shared savings it was unclear from the data even after we got it where they changed our base, you know, rate for reasons that were unclear. The ones in our market that are still of higher cost than we are were the ones that actually achieved shared savings.

So, this is almost a counter point to readiness that Karen was talking about earlier because it was sort of ironic, I've seen some of the shared savings results. If you started off with really high costs there was more opportunity than if you were already in an efficient player.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

It definitely is a Rube Goldberg that lends a lot of anxiety to the other issues that are already very anxiety prone about, you know, attempting a venture like an ACO in the first place.

So, you know, we just need to – if we're going to talk about accountable care I think it's time to talk about accountable care and CMS is the driving force I understand that but it has to have some commonality with the market as a whole and again, as we engage commercial payers it's a completely different vision when it comes to how do you structure a shared savings.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

So, Frank is it almost two different issues here, one is the business incentive structure offered by CMS adequate to have people enter this marketplace as it becomes more clear where it was fairly opaque for the initial pioneers.

And then the second question is if you are in this marketplace are there opportunities to at least measure how much burden there is to document your participation and ways to streamline the administrative overhead of doing so, but that's separate from the question of whether the incentives are – one is incentives and one is overhead almost.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Well, you could look at those as two separate issues but they're really tangled up a little bit and I don't want to waste a lot of time on this, but this is, as Grace said, kind of near and dear to my heart.

The thing that we've got to understand is that there are no incentives today. After this interim financial reconciliation results are released I would say let's look at the results of the applications for 2015 startups and you're going to see a serious drop.

R. Hal Baker, MD – Vice President & Chief Medical Officer – WellSpan Health

Yes.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Now that's not good, that's not good for what we're attempting to do. Because what we've done is we disincentivized people to get involved. Now that's for new people coming on board so if you turn off the inflow of new participants the program will ultimately die.

Number two, the existing ACOs that are contracted now and that will soon come up for potential renewal of those contracts, unless there is a serious change in the way that those contracts are written there will be no incentive to move forward because our physicians will not have achieved shared savings even though we are predicting, we are predicting that CMS will save well in excess of what they funded us – so at the end of the three year contract or it's really four years for operating purposes, CMS is going to –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Just a reminder if you're not speaking if you could mute your line it would be appreciated we're getting a little bit of feedback, sorry.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

That's okay. So, you know, if CMS is okay with doing a three year deal and getting a 1 or 1.5% savings rate and then losing that contract with an organization that actually did lower cost from the initial benchmarks 3 years later, then C'est la vie, that's the way it goes.

But, again, when we talk to commercial payers we don't get into these – we don't have these conceptual time lags when we talk to commercial payers. They're succinct about we're going to measure you against your market and if you beat that market then there are going to be incentives in that for you, because they know that if you pump the lake all boats go down and I don't see that as part of the strategy here with CMS. I just don't see it.

Now, I'm going to shut up because I know I've kind of crated the agenda and we were making really good headway too, so –

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Well, I just felt like it would be important for you to get some of that articulated because this seems to be the place for it. Let's go to the next slide which were the priority recommendations in more detail. When we finished this one it will be – I think it looks like we're actually pretty close to being on schedule with our discussion, so any comments here?

All right, Frank, you ready to – not Frank, Charles, are you ready to – he called me Karen and I called you Frank, are you ready to drive the car again and talk about next steps?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Oh, yeah, sure Frank is ready to drive.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Sorry.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

No, no, no that's okay.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

No that's fine I'm just kidding you. So, a couple of things, as I was listening to that conversation about, you know, ACOs and I did see that article you referenced about Universal American I think it was in Modern Healthcare as I recall so that's – I don't know I think we should strongly, you know, consider putting a couple of priority recommendations in there around the administration of the program along those lines, I think that was really good commentary.

In terms of – so with that as kind of I guess a closing comment, what we're going to do is take what we heard today and make one last kind of set of recommendations, circulate it one more time and then present it to the committee on July 8th.

So, now there is substantial change going on within the Office of the National Coordinator and the associated way that the HIT Policy Committee is structured to move forward. So, they're going to evolve the Workgroups and so this is kind of our last and I guess only major deliverable of this Workgroup and so when we present it on July 8th that will wrap up much of our work and these Workgroups will be evolved into the structure you see on slide 21.

And so I don't know if any of our colleagues from CMS have any additional comments they want to make about Karen's leadership in this new direction, but just you see the overall structure – I don't really know that much about it other than what she said at the Policy Committee meeting, but you see the overall structure on 21 and then of note on slide 22 I'll just make one more comment which is we seem to be moving from a focus on Meaningful Use to an – still Meaningful Use being important, but a greater focus on some of the specific areas of pain that remain outstanding in how we evolve our nation's HIT infrastructure.

The JASON Report, as you see on slide 22, is going to generate a taskforce I thought that was a pretty interesting report on interoperability and HIE, a safety taskforce and an overall strategic taskforce as well as an advanced health model and Meaningful Use taskforce. So, I think you're seeing us evolve.

I think Karen is trying to evolve us into more of a tactic focused, issue focused type of structure which I actually welcome and I'm cautiously optimistic this will be very helpful as we put together more recommendations to move the country forward here.

So, I don't know if Alex or others have comments they want to make about the changing and the structure?

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Charles, this is Michelle from ONC, not CMS, we're having trouble with names today.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

I hear you.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

So, Caitlin if you can go back to slide 21? So, at the past few Policy Committee meetings we've been talking about the evolution to our new Workgroups and I think Charles actually described it very well about we're just hoping to align with the future direction of ONC over the next decade or so and so you can see some of the Workgroups aren't really changing much at all and others are changing significantly and are transforming into the Workgroups that you see here.

Actually, today there was a blog posted on the Health IT Buzz Blog asking for people that are interested in and applying to be members of the Workgroups to apply. So, we encourage you to go in there and apply if you already have an application you can just update your current application and indicate where you are interested in participating.

And we thank you for your work on this group and as we kind of work to wrap things up at the July 8th Policy Committee meeting we hope that those who are still interested will apply and will be willing to participate in these Workgroups going forward. So, thank you and Alex or Kelly I'm not sure if you want to add anything else, but we greatly appreciate your participation.

Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology

Yeah, this is Kelly, I would only add that I think a lot of the work that you've done over the last year or so and this final deliverable is going to shape the sort of future work for the Advanced Health Models Workgroup. So, it will be really a continuation of the work that you're doing and in many ways sort of the recommendations will be sort of a starting point for the follow on.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Well, very good then with that I think we can begin to open the lines up for public comment. I'll just close this part of the agenda by saying and I'm just going to list everybody here, my colleagues at HHS, CMS, ONC, Grace as the Co-Chair and all of you on the Workgroup thank you so much for your time, your effort, your focus on putting together these recommendations. As we said, they were very well received. I think they're going to be helpful in guiding the intersection of HIT and ACOs and thanks again for your time and let's open the lines up to public comment.

Public Comment

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thanks, Charles, operator can you please open the lines?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment please press *1 at this time. We do not have any comment at this time.

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna

Very good, thanks everyone, have a wonderful rest of the week and weekend and thanks again for your participation.

Grace E. Terrell, MD, MMM – President & Chief Executive Officer – Cornerstone Health Care, PA

Thanks everybody.

Frank Ross, MSSP, AP, ACO – IS/IT Steward – Cumberland Center for Healthcare Innovation

Thanks everybody.

Karen M. Bell, MD, MMS – Chair – Certification Commission for Health Information Technology

Thank you all, bye now.