

**HIT Policy Committee
Accountable Care Workgroup
Transcript
June 7, 2013**

Presentation

Alexander Baker – Office of the National Coordinator

Hi, this is Alex Baker with the Office of the National Coordinator. I am going to be introducing this call on behalf of MacKenzie Robertson and just a couple of announcements before we get started. I want to remind everyone that this is a public call and that there is public comments built into the agenda at the end of the meeting. And also want to remind folks that this call is being recorded, and if you could please identify yourselves that will be very helpful. And with that, I will turn to the list of Accountable Care Workgroup members, if people could just respond that they're present when I say the name. Charles Kennedy?

Charles Kennedy, MD, MBA – Chief Executive Officer, Accountable Care Solutions – Aetna
I'm here.

Alexander Baker – Office of the National Coordinator

Thanks. Shaun Alfreds? Hal Baker?

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Present.

Alexander Baker – Office of the National Coordinator

Thanks Hal. Karen Bell? Karen Davis? John Fallon?

Caitlin Collins – Altarum Institute

Just a reminder to everyone on the phone, please mute your computer speakers if you're also dialed into the webinar to prevent that echo. Thanks everyone.

Alexander Baker – Office of the National Coordinator

Thanks. Heather Jelonek?

Heather Jelonek, MS – Chief Operating Officer – John C. Lincoln Accountable Care Organization

I'm here.

Alexander Baker – Office of the National Coordinator

Thanks Heather. David Kendrick? Joe Kimura?

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

Present.

Alexander Baker – Office of the National Coordinator

Thanks Joe. Irene Koch?

Irene Koch, JD – Executive Director – Brooklyn Health Information Exchange (BHIX)

I'm here.

Alexander Baker – Office of the National Coordinator

Thanks Irene. Aaron McKethan? Eun-Shim Nahm? Judy Rich? Cary Sennett? Bill Spooner? Susan Stuard? Grace Terrell?

Grace Terrell, MD – President and Chief Executive Officer - Cornerstone Health Care, PA

Here.

Alexander Baker – Office of the National Coordinator

Thanks Grace. Karen Van Wagner? Sam VanNorman? Akaki Lekiachvili? Mai Pham? John Pilotte?

John C. Pilotte – Director, Performance-Based Payment Policy Group – Centers for Medicare & Medicaid Services

Here.

Alexander Baker – Office of the National Coordinator

Thanks John. And Westley Clark? Great. I think that does it for roll call, and with that, I will turn it over to you Charles.

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

Very good and good afternoon everyone. Let me start out the meeting by just offering a brief review of the agenda. One of the things that we thought would be an important area to cover would be the area of health information exchange. As all of you know, an accountable care organization, one of its foundational tenants is that we are attempting to build in many ways a virtual care system. One where information is exchanged between doctors and patients more seamlessly, data liquidity is frequently used as a term, with the goal of allowing care to be more coordinated and more integrated and the expectation of cost savings and quality improvement as a result. Many organizations see health information exchange as a foundational enabler of an ACO and so we thought it would be important for this workgroup to have Micky Tripathi come in and talk to us a little bit about the state of health information exchange and begin a dialog around the intersection of health information exchange and its value in accountable care organizations. So we're going to start with that discussion in just a few minutes.

And then Karen Bell, who's a member of the workgroup, but also leads CCHIT, they've been doing a lot of work in the alignment of their CCHIT activities with creating a framework for what we really need from an IT perspective to be successful in an accountable care organization. And so, I didn't think I heard her in attendance, but I'm sure she'll dial in momentarily, and once that conversation is completed, then we will talk a little bit about where that work is headed and how we can potentially either leverage or align with it in our recommendations to the HIT Policy Committee as we move forward. So, that's the set of activities for today. Micky, I believe I heard you earlier on the call.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Hi Charles, I'm here.

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

Great, well, can I turn it over to you and we can start the discussion.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Okay, great. Yeah, thank you. Thanks for the opportunity to speak to the workgroup on the work from my workgroup, the Information Exchange Workgroup. We and I think all of you have the slides, as I was explaining on the pre-workgroup call; I'm in the car, so I'm not going to go through the slides slide by slide. Also, I don't think that that would be entirely helpful to the workgroup, because the presentation I'll be drawing from – is everyone still there?

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

We're here.

Male:

Here.

Woman:

Yup.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, sorry, I just heard a very strange echo. The presentation that you have is a presentation that presented our workgroup's responses to the recent ONC CMS RFI on health information exchange – expansion of issues, only some of which I think are going to be interesting to your workgroup ahead. So the three things that I would point to in that, that appears to me could be most helpful to you with respect to ACOs are the recommendations related to payment and some of the things that flowed from that. The recommendations on eligibility of other providers or the ineligibles as we call them, those policies related to those providers who were not eligible for meaningful use and there's a third one that I'm spacing out on, but I'm sure it'll come back to me as we walk through it. So why don't I just explain briefly what was in those three categories or in those categories and then, if you have any questions specifically about those, I'm happy to answer them, or if there are any particular things on any of the slides that you'd like further elaboration on, I'm happy to talk about those as well.

So the first set of things, basically what we did in the presentation is we noted, and I should say that also, with respect to the presentation, it was focused specifically, if you recall the RFI, that was focused specifically on what actions can government take to improve and accelerate health information exchange capability across the country. So it wasn't a broad consideration of what are all the possibilities – what are all the barriers out there and what might be the broad set of enablers. It was specifically – the RFI was specifically focused on what are the barriers that government might be able to help alleviate, some of them self-imposed, some of them not. So again, that's just sort of a context setting for the things I'm going to talk about.

So in terms of the payment models themselves, one of the things that we did note is that first and foremost, as the market is moving to value based purchasing and accountable care and obviously the CMS is really instrumental in helping to drive that with the Pioneer ACO Program and Shared Savings and what have you. A perhaps more specific focus with some of those payment models for HIE enabled functions could be an area that they might want to consider. So for example, for an organization that has Pioneer ACO contract or a Shared Savings contract, if they really thought that they wanted to sort of focus specifically on enabling health information exchange in a more focused, targeted way, they might want to consider perhaps a greater incentive, in some way, for particular functions that require HIE enablement. Because I think, as we know, there are a variety of ways of accomplishing certain things and deploying or employing specific HIE functions may be one of a set of ways that they could do that, some of them manual or paper-based versus others that are more automated in a health information exchange kind of way. So that was just one specific thing that we noted that if they really wanted to do that, they could focus more on it.

The other side of that would be on the supply side, which is thinking about the technology infrastructure. And that's where we were just noting that the EHR certification program, I think, has been incredibly valuable in terms of raising the floor of capability year on year so that at least providers in the market can have some degree of assurance. We know it's not perfect, and we know that there are lots of gaps and lots of ways the vendors are getting around certain things that we might expect would be in those systems, some for good reason, and some for bad. But be that as it may, there has been, I think, considerable progress in standardization of systems, but we also noted in the workgroup that as meaningful use starts to – we start to get to Stage 3, there may be a Stage 4 or Stage 5, and Stage 6 based more on the penalties rather than the incentive. But that said, I think that there certainly, at least our experience, the members of the workgroup as well as my own personal experience is that the meaningful use impact is waning, I think, in terms of provider traction and people's attention to it. Whereas, as we know, ACO and value-based purchasing in general is sort of going to pick up the baton, I think, and be the driving force going forward in the market.

So that was, and I give that as background to the set of recommendations that we had related to consideration of certification program that I focused specifically on ACO enablement. And we noted that you could think of that in a couple of different dimensions, really picking up from where meaningful use left off, so with respect to the depth of capabilities, greater semantic interoperability for example, around vocabulary and nomenclature. We know that Stage 2 and Stage 3 are going to hopefully tighten some of that up, but we know that as we start to move into Stage 3, we're only going to be able to get so far with that. And in particular, when you think about how broad and generic meaningful use is, in certain ways, it may never get to the type of focus in terms of depth of capability and integration of workflow in the applications themselves that's something more focused, like accountable care can start to drive. So, and again, there is a slide on that in the appendix, I think it might be slide 14 or 15, I forget, that speaks a little bit to the depth consideration.

And then with respect to breadth, that would be to say the certification you could think of it applying to a broad set of systems. So right now, as we know, it only applies to those who qualify for meaningful use. Others can pick up those systems, but the vendors who serve the providers who were not eligible for meaningful use in the first place, have been much slower to respond in the market. Some of them are selectively doing things that would qualify for them for certification if they wanted to, because the market is driving them there, but that's really a very ad hoc kind of process and it's not nearly as focused, as more focused certification would get them. Now I think Karen, and I know she's going to be on the call a little bit later I heard, she at CCHIT did try to have certification around certain other types of systems like I think long-term care was what they tried. They got no takers, but – so I think that that experience suggests that there would need to be greater oomph from the ONC side perhaps, to formalize that a little bit more. And there are certainly a lot of questions about whether ONC has the statutory authority to do that and whether they have the budget, I mean, that would be a two-part consideration. But that might – could form a set of recommendations to them that they try to seek that kind of authority or budget if they need that.

So those two things cover the refinement of payment models focused on HIE enablement, as well as on the supply side or the infrastructure side, thinking about how certification could help with ACO enablement and vice versa or ACO enablement could be – it could essentially pick up the baton on the certification process and take it to the next level.

The other area that I would point to, and then I'll stop, is related to the ineligible. And to the extent that ACOs are – encompass a broader set of players and I think in its ideal form, would be looking at across the entire value chain or across the entire chain continuum, and as I've noted just earlier, a lot of those players are not, right now, a part of meaningful use. And so they have a different set of incentives that they're responding to. Anything that can start to standardize the types of things that they do in alignment with the kinds of infrastructures and policies that we put into place for meaningful use would be things that would be very helpful, I think, for accountable care, for the market in general and for the quality of care in general, but for accountable care in particular.

So, we had a set of recommendations related to the kinds of reporting requirements that things like home health care, long-term care organizations, and the whole LTPAC infrastructure. They have OASIS, MDS, a whole variety of things that are driven by CMS and are requirements of CMS, but are right now relatively unconnected to the kinds of infrastructure that we're putting into place for meaningful use, CCDAs and all of that. Now I know Larry Garber, who many of you know, has been driving very hard to get the long-term care as well as home health care and a variety of those things incorporated in the CCDA infrastructure, so some of that work is already happening. But it seems to me that there could be some possible fruitful pathways there to work with ONC or other – actually, not ONC – past ONC and other parts of CMS, to see what parts of those might be enabled in a way that would bring the ACO model together more sharply.

So there are certainly other things in the presentation that I think that one could imagine could indirectly serve the ACO needs, but at least as I was looking through the presentation earlier this morning, those are the ones that jumped out at me as being most directly connected to the work that I think is in front of you. But let me pause here and see if you have any questions on that or on anything else that we covered in the presentation.

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

Well thanks Micky, I'll start and maybe others will jump in. One of the things this subcommittee might be helpful in doing is creating more of a tangible linkage between some of the foundational technology programs and policies and incentives that you were describing, such as health information exchange and the higher order types of function that an ACO would be interested in, such as transitions of care, right. I mean, I think virtually every ACO in our network, and virtually every ACO that I've talked to, identifies transitions of care as a priority going forward. Now, one would think that the Health Information Exchange Workgroup and the activities around CCD and the use case associated with CCD would slide in quite nicely with that need. But in many of the conversations I have, it feels like there's a pretty substantial gap between the realization – the value of the technology standard and the potential realization of value to the ACO. Any comments around that, or has the Health Information Exchange Workgroup kind of looked at the linkage between a particular standard like a CCD and the enablement of value creation that an ACO or any organization might see in any way?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, no, it's a great question and obviously incredibly important. That, just as a matter of sort of jurisdiction isn't in the Information Exchange Workgroup, but the Care – I think it's the Care Coordination subgroup of the Meaningful Use Workgroup is covering that. So I know we've been working with them, just – they invite us to all of their meetings, because there obviously is a little bit of an overlap, but we've sort of given them the primary responsibility for driving that in terms of CCDA content and structure. And Larry Garber has been working pretty diligently with them to expand the CCDA definitions, for example, from I think the 145 clinical terms that are in there right now to an expanded set of 300-400 that he thinks are required for LTPAC functions themselves, for example. So, I think that would be the place for the CCDA content part of that.

The other parts, just since you'd mentioned where we're headed with the Information Exchange Workgroup, we're going to be focusing for Stage 3 and would love your feedback on if you think there are other areas that we're not covering that we should be. For Stage 3 where we're going to be focusing is on three things. One is –

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

Uh oh, I think Micky hit a dead spot in a tunnel, yup.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator

Charles, this is Kelly Cronin. I can in part answer your question too, just from an ONC perspective.

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

Sure.

Kelly Cronin, MPH – Health Care Reform Coordinator – Office of the National Coordinator

Stage 2 requirements for certification should up the bar for a lot of EHR vendors or any vendors that are enabling summary record exchange to meet the transition of care measures in Meaningful Use Stage 2. So we do have – that more highly specified standards and the certification to – against those standards should be a lot better in the next year, but it is an evolution. And I think Larry Garber's work Micky was talking about specific for long-term care will be a more highly specified standard that will have over 400 data elements, at least that's what's being balloted now by HL7. And that can evolve standards that could be specific to health IT systems in long-term care, if ONC moved forward with formalizing a certification program for long-term care. So it's – work in progress.

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

Great.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Collaborative

It's Micky Tripathi, I'm back, sorry.

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

Okay, no problem.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

One of the two known dead spots on the Massachusetts Turnpike, so I think we're okay.

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

So –

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

– as I was saying, queries for patient record is one focus area for us, and I think that certainly from an ACO perspective that would be pretty important. And then the other is provider directories, which I don't think are a central focus, but obviously important to the underlying infrastructure for HIE enablement for ACOs or anything else.

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

Um hmm, um hmm, okay. Some of the other, and again, if others have questions, please jump in. One of the other areas I commonly hear is an area of challenge, especially in some of the Pioneers that we work with, involves data, both timeliness and receiving it in non-standard forms from CMS. And given that, there's claims data, even though CMS has, I think, done an admirable job of reducing the latency of the files that they share with their ACO customers or partners, it's still pretty latent from a clinical care delivery perspective. I was wondering if you had any thoughts on how, once you knew who your members were, whether health information exchange or that infrastructure might be some kind of vehicle to kind of maybe in not getting the claim data, but if there were some ways to, through a federated exchange or a search capability, maybe get some of that clinical data in a more timely way?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Collaborative

Get the clinical data in a more timely way?

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

Well if you can't get claims in a timely way, but let's say you get an initial dump that says, oh, okay, here's the universe of patients that I'm focusing on, I don't know could health information exchange give us a way to supplement the latent claim data perhaps with more timely clinical data – ?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Collaborative

Got it. Yeah, so we haven't looked specifically at that, but that's certainly one of the goals and objectives of health information exchange generally. Although what I would say is that there's different – we're sort of in the HIE 2.0 world right and not in the 1.0 world and what I mean by that, is health information exchange is going complex, just like the market in general and like technology implementation in general. And so we have multiple layers of HIE that are kind of emerging and so, as I see the market and this is a little bit more of my own personal view than it is of the formalized workgroup, is that for ACO enablement there seems to be a lot of HIE activity. So called private HIEs that are spawning, at least in the market that I'm familiar with, all over the place and very focused on ACO enablement especially, because they're seeing in many markets that a statewide or a regional HIE is not going to be able to solve their specific focus needs at the ACO level.

So what we're seeing for example, in Massachusetts is that there are many private HIEs that are spawning, really driven by an ACO type of organization, like a hospital and a bunch of practices who either are considering themselves an ACO without a contract or more commonly, they either have a – they might have a Pioneer ACO contract or a Shared Savings contract, so they have very specific focus. And then they are building that kind of repository style HIE, which would in real-time be populated from all of the information from the participants. And then, to your point Charles would essentially be an immediate source of clinical data that could provide immediate information in a cross-sectional way, as well longitudinal going backward and could be a supplement to whatever claims information they have. And increasingly they're starting to look at how to integrate the claims and the clinical as well, again, because they're very focused on serving that ACO business need.

The statewide HIEs I think, I'll just sort of make a somewhat controversial statement, but I think it's very hard to imagine any statewide HIE that I'm familiar with meeting the ACO needs of any particular ACO. Unless it's like a small state, who's been at it for a while, because the ACO needs, at least that I'm familiar with and the organizations I'm familiar with are so focused and so – they're very focused, they're fairly rigorous. And they have pretty fast timelines that they're working on, and that's just not the nature of what statewide HIE activity is about, that's sort of broad collaborations, many different priorities and hard to get really deep functionality fast.

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

Yup, yup. Great. Maybe we should follow up with Massachusetts, I think you said, we'll contact you, maybe we should follow up with those organizations to get an idea of what they're doing because it sounds like they're going down a path that would help an ACO in terms of the HIE functionality to make an ACO successful, so maybe we'll take that as a follow up.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Sure, I mean, I'd be happy to put you in touch with them.

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

I mean do you want me – this is Joe Kimura from Atrius Health, do you want us to talk a little bit about what we're doing here with some of the hospitals?

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

Well, we're a little short on time for this and unless Karen Bell hasn't joined, Karen, are you on the call?

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

Oh yeah, no, I'm on the call. I was muted by mistake by Altarum, but I'm here.

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

Okay.

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

Okay, we'll have a separate call on that specific item. Let me just pause here and see if any others have questions they would like to ask Micky. I've got a couple more, but if any others have questions.

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

This is Karen again, could I just make a comment about the certification piece as well, because I think it's very important to recognize that certification has to have some sort of a business case in order for it to meet the needs of whatever program the certification is about. So, it is true that a lot of effort went into a long-term post-acute care certification program at CCHIT in the past, and there were essentially very few takers on it. I think that when we think about certification in this environment around health information exchange, I'd like to just underline what I think some of the other commenters have focused on, and that's that we may not want to be doing full meaningful use certification. And if we are going to really think about something that's useful and people will want as part of their own business, we would need to really think very carefully about the use cases for which certification would be most valuable if a program is developed outside of the current provider EHRs that are in the current ONC certification programs. So I just want to not lose...have us lose track of the fact that focused certification may be something we would want to consider very carefully.

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

Okay, great. Others, any others?

Aaron McKethan, PhD – Vice President of Strategy and Business Development – RxAnte, Inc.

Yeah, this is Aaron McKethan; I just have a question for Micky. That is, there's been a lot of attention, not so much today necessarily, but in general in the context of ACO formation and policy development around getting them the claims data and so on. I think CMS has done an incredibly admirable job of rapidly, with relatively constrained resources for this, figuring a way to get much faster, much better data to these organizations. If you just look back over time and think about the PGP demonstration and the 646 demo, which are both sort of prototypical ACO demos, they've come a long way very fast in getting good information, good enough information that these entities, even though of course there's always room for improvement. But my question actually is, while the attention's been on that topic, what about our sense of how the ACOs are actually able to use this information?

Back in the day when the 646 demonstration and some of these other earlier efforts were up, all the attention was on how do we download the files from CMS and get them going and so on. But as I talked to those organizations back then, there was this big question of, okay now we have the data, how – beyond the kind of obvious low-hanging fruit things we can do with it, what – how are we ensuring that the ACOs have the capacity and know exactly what to do with it from an analytic perspective or from a population health perspective. Is there any comment on that Micky or just a read on how the market is responding to the new data coming out?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Sure. Yeah, I mean that isn't really a topic area of the Information Exchange Workgroup, but I'm happy to respond based on my own knowledge of the market and what we're doing. Is I think, as you suggested, kind of the capabilities are all over the map and people are just starting to get an understanding of what they might be able to do with it, that's sort of – and probably also a sense of shock that they're actually getting the data. So, getting over that shock and then trying to figure out what they're going to do with it, I think, is – and highly variable capabilities across the market. But at least from what I've seen, some of the biggest challenges are figuring – trying to figure out the merging of the clinical and the claims in a meaningful way.

So, we, just as a separate note, so we're – my organization, the Mass eHealth Collaborative, is a non-profit organization. We have a quality data warehouse that I think, for those of you who follow John Halamka's blog; he's talked about because we are the quality data warehouse for Beth Israel Deaconess Care Organization, which is a Pioneer ACO. So, we get all their clinical data and then we are now working with them on integrating that back with the claims data, which they have in a separate claims warehouse. And some of the things that we're starting to do with them, and we're learning together and growing together on this, is starting to take their ACO aligned patients, for example, which they get from CMS, as you know, and mapping all of that back to the quality measures, the clinical based quality measures. They've been able to do it from the claims side, because that's the world they've been living in, but we're now starting to match all of that with the clinically based quality measures that we've been calculating now for a couple years. And so, and then they're going to start to use that into – and integrating that back into their care management processes, so they have a much richer set of information to enable much better care management processes than they've had to date. As well as the ability to actually look at real outcomes and think about that in a risk management context and risk mitigation strategies going forward.

The other – so that’s just on the – at least from what I’ve seen, the awareness is starting to grow, but a lot of organizations are still just trying to figure out how they would bring the claims and the clinical together. And then some organizations, like – are taking the next step now with those tools, to start to bring that together and thinking about starting off with the rudimentary tools that you always start off with. And then I think we’ll start to see greater complexity grow over time as we all start to see the possibilities that come when you start to bring this together. From an administrative perspective, the other thing that we’ve been able to do is help them help match the clinical data with the claims so that they can do automated uploads into the GPRO tool. For example, I think as you know for the Pioneer ACOs and I think for the Shared Savings perhaps, they have to use the GPRO tool, which would have been kind of nightmarish if they were trying to do that individually. So we were able to give them automated data out of the clinical data warehouse that they were able to – that covered 75% of their GPRO admission, in an automated way. So that’s more on the administrative side, but just another example of what you can do when you start to put this stuff together.

Heather Jelonek, MS – Chief Operating Officer – John C. Lincoln Accountable Care Organization

And this is Heather Jelonek from The John C. Lincoln ACO, we’re in Phoenix. We are also starting to be able to make heads or tails of the claims information we get from CMS, but the issue that we struggle with is the fact that so many of our patients are MSSP attributed patients, are snowbirds. So while we may get the information from CMS, the patient’s only spending 6 months of the year here, maybe 9 months of the year here. And we know the test, for example has been done, the A1c, but we don’t necessarily have the result in our system because the patient may have received that service in New York, for example. So what we really need to see is hopefully some kind of national HIE where we can tap into that data, our state HIE is not going to help us in that endeavor.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Yeah, so I’m – I hate say it, but I think you’re going to have to think of other tactical solutions before waiting for a national HIE.

Heather Jelonek, MS – Chief Operating Officer – John C. Lincoln Accountable Care Organization

Oh yeah, I mean fortunately we’re live on EPIC and they’re in most of the major health systems across the United States are live on EPIC, but just in terms of connecting, even if we can get the states to all connect, it would be helpful. Because again, you know the test is done, but then you’re going to spend literally hours trying to track down what that actual result was.

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth

Collaborative

Right, right, right. Yeah, I mean, challenges you know, I think as well as I do, that there’s a – the state level HIEs are going to be facing a fiscal cliff here soon, which is going to be a real challenge for all of us.

Heather Jelonek, MS – Chief Operating Officer – John C. Lincoln Accountable Care Organization

Yup, it’s just something –

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

Yeah Micky, that brings up just one last question before you go which is, there’s been some talk in the literature about the challenge of the state level HIEs not having a sustainable business model, and I’ve seen more than a few articles about ACOs as a potential vehicle to resolve that problem. What are you all seeing in the industry around HIEs and ACOs from a business model perspective, if anything?

Micky Tripathi, PhD – President and Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, I sort of – I really don't necessarily see how ACOs will save state level HIEs except for those state level HIEs that are able to pivot and not – and try to solve problems that the ACOs themselves can't solve and that aren't central to what the ACOs do, and do that in a low cost way, I think that that's the only way that they'll be able to survive. So what do I mean by that. That at least from what I'm seeing, and I know Joe's on the phone from Massachusetts, so he knows the Massachusetts market as well, there's a lot of focus on – to the extent that there are resources that are going to be spent on HIE, they're being focused, I think, on – so again, so called private HIEs. Because that's the only way for them to be able to stand up a deep and rich functionality in a timely way that they need to meet their immediate needs, with regard to taking on risk. So that is a negative, in the – with respect to the state level HIEs because those are resources that some portion of which might have been devoted to paying – helping to pay for a state level HIE, which are now being diverted to the private HIE.

On the other hand, it's not like you can prevent leakage, either within your state, you're going to have patients who go to other places, regardless. And there, I think as a general matter, just in terms of standards of care, there is a need to have that kind of cross-ACO or cross-private HIE functionality. So that it seems to me, is where the state level HIEs can add value that the private HIEs aren't going to be able to accomplish on their own. In part because for each private HIE, I mean just to think of it very simplistically, that might only be 10% of their problem, so they're not going to devote resources to it. But the state level HIE in effect can take the 10% problem that each of them has and say, here, I can offer it to you at a price that would only be 5% of what you would have to pay. And then you can get that kind of interest to say, okay, we'll pay a little bit toward that to solve that problem for us. So we're seeing that in New Hampshire as well as being a model that can sustain the state level HIE, but what is key there is that the state level HIE be able to do that at low cost. And at least in Massachusetts and New Hampshire, what we've focused on is, in Massachusetts we're able to leverage Medicaid dollars, so Medicaid is paying for 80-85% of the ongoing operation of the state level HIE, so that solves most of the sustainability issue right there. In New Hampshire what we've done is focus on a very lean set of services that we're offering at the state level in order to keep the cost down. So, that's where we've said specifically, we're focusing on cross-ACO capabilities and not trying to solve ACO problems. So we're not going to be big repositories, we're not going to build rick applications, we're just going to create a network that connects up those ACOs and skim on the top of whatever money they've allocated for the HIEs in general, knowing that most of that is going to be invested in their private HIEs.

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

Got it. All right, well Micky we could probably go on and on, but we're running short on time. I want to thank you for all the information you provided to this subgroup and now we'll transition over to Karen.

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

Great, and in the interest of time, I'm going to ask that we start with slide 5 because I just spent a little bit of time last month talking about why we got into creating a framework, its value and a number of other things, which are on your slide set, so you can look at those in greater detail. But I wanted to start out with this particular slide, so I could really call out the folks who came together and worked very hard to initially build the framework. That's the commissioners on the left-hand side, and then particular kudos to the members of the panel who did a lot of work, specifically around the glide path, which we'll get to shortly, so just wanted to make sure that I could call out our appreciation to everyone who contributed to this work. I would like to just point out also again that this was a consensus document and it comes in three parts. And so if we can jump right now to slide 8, again, I'm trying to be cautious about time here.

This is the summary, this is the first part of the framework, and this is one of two pages on the summary document. And the points that I'd like to make here is that this framework represents a provider orientation. If you look at the three aims up there, they are not the same three aims that are in the ACO rule; these are the ones that are going to be relevant to providers who are taking on accountable care contracts. They need to make sure that they have the high quality care that they are looking at cost efficiency and that they can maintain customer loyalty as well as the support of their provider groups, has the provider loyalty as well.

The second point I'd like to make here is that, if you go to the next slide, this is a very processed oriented summary, there's very little about HIT here, we'll come back to the HIT primary requirements in a moment. But there are 70 processes, as I identified last month, and there are 64 different functions to make those processes work optimally. So this is really all about the processes that an ACO should probably consider, recognizing that not every ACO is the same, not every single one of these will be pertinent to an ACO. But anyone that is moving into this arena should probably at least think about all of these things and make a determination about what it is that they're going to have to do to be successful moving forward.

The next slide brings us back to the primary HIT requirements, and I really do want to emphasize the importance of these. Micky just gave us a great introduction and discussion on the importance of sharing health information. We were not specific about how that should be done. One of our colleagues mentioned that it works quite well if everyone's on the same EHR, it can work quite well if there is a local or a state HIE to help along. But I think the important message here is that these four primary considerations or these four primary HIT requirements are consistent across all ACOs. Again, they all can be done differently, but data into the HIE has to happen, sharing of health information, data integration from multiple sources depending on what that particular organization has for its goals, will have different sources for that data. But it will have to have that data integration, which we've just talked about as well. Patient safety features are important, as well as privacy and security protections. And I think the reason I did want to focus on these is because given the dynamic nature and all the diverse types of ACOs that are out there, this is a – there is a consistency here that could lend itself for us to really think about what kind of policy recommendations we might like to make in these four areas. We've started a little bit of discussion already on that, but in spite of the fact that there's an awful lot in the rest of the framework, this may be an area we might want to think about in terms of policy going forward.

I won't entertain comments right at the moment, I'll just move along and then we'll entertain them in a few more moments, because I know we are a little short of time here. So I'd like to now jump to slide 12, because this is the second part of the framework. What we did in part two, which is where we outline our HIT capabilities, was to take each of those key processes that you saw on the summary table and devote one page to explaining them in detail, which I don't have here. But what I do have here is the first page of functions and their supporting HIT capabilities just as an example for you to see the level of detail that we've gone into on all of the 64 functions on this framework. I think there are some important features that I'd like to highlight here as well. You will note that some of these have a little asterisk on them and those identify the ONC 2014 edition certification criteria. Now, there's – it's not exactly a perfect match, there are some situations where the ONC criteria may be a small part of the full list of capabilities that we think might be necessary for a function, but wherever there is a match, it's been asterisked.

Secondly, given the fact that we had a lot of emphasis on patient safety in our workgroup and for those of you who may not have seen the announcement, but Tejal Ghandi, who was on the workgroup, is now President of the National Patient Safety Forum, and was extraordinarily helpful in pointing out that anything related to communication, follow up, diagnosis would be something we might want to bold here. So, throughout the entire capabilities part of the framework, you will see bolded capabilities, as well as the asterisked ones. Before I go into part 3 now, I will stop for a moment just in case anyone has any questions that they may have at this point.

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

Hey Karen, it's Charles. In looking at, I guess I'm on slide 11 that has care coordination, cohort management, patient, and caregiver relationship management across the top in a variety of colors, while I would agree that virtually all these things on here are things that an ACO would either be interested in or would need to do to be successful. Did you create any kind of prioritization – in other words, did you look at what might be the lowest hanging fruit that might give you the greatest return or did you look at what might be the easiest to implement or the shortest to implement any kind of a prioritization approach?

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

We did and actually that was the advisory panel's, I think, most significant contribution. If we go to the next – well, let's see, I guess it's slide number 14, we talk a little – it's where we introduced the glide path. Before I get into this, I just also want to point out that we were not prescriptive in any of this, as to whether or not it has to be in an EHR or whether it can be a complimentary technology. We were not prescriptive as to who does what; we really encourage partnerships here, by assuring that there is the opportunity for interface or for integration among all products used. So, we were very clear that there are multiple ways to skin this cat, but one way or another, depending on what type of an ACO you might be, there are certain functions and certain capabilities you would need.

Now coming to your point Charles, we developed a glide path because it became very clear to us that an ACO is not an ACO is not an ACO. Each one has different goals; each one comes to the arena with a different set of structures and processes already in place and with different cultures. So we recognize that not every organization was going to come to the table wanting the same set of capabilities. And as part of that, we thought well, what was really most important here was recognizing that the environment is changing and that this is really about healthcare transformation, so functions and HIT capabilities are going to be more limited in early stages, as we move along. So the next slide, I think is the one that addresses your question most effectively. And here's where we put a lot of time and effort into really thinking through, what does it mean to really go through healthcare transformation? Clearly financial risk will change, there needs to be some incentives to do it, but how one incorporates the patient and how one deals with the patient changes as time goes on. Clinician culture changes, how you think about quality of care, right now it's all about reporting. We just spent a lot of time talking about that, but ultimately it has got to be about process change. And cost control ultimately has to be about new business practices as well.

So as different organizations move along this continuum in different places, I mean some may already be doing a lot of clinical process improvement, others may need to put more emphasis on clinician culture, they will have to think differently about their HIT roadmap and infrastructure. So the bottom line here is that, and I think everyone would agree, you have to start off with at least with an ONC certified EHR technology for 2014. We just talked about in some size, shape or form doing all four of the primary HIT requirements, though again, it will be dependent on the organization's goals and what they have available to them. We felt quite strongly that all care coordination functions, particularly those with the provider-based HIT capabilities for patient centric information would be important, all cohort management functions and some selected clinician engagement functions. So, what this is essentially a way of saying, if you're moving into upside risk only, look carefully at what's in column one. If you're moving into significant upside risk, i.e. a lot of your patients are an upside risk, and then start adding – thinking about adding some of the ones that are in column two. And if you are really taking on significant risk, either forms of capitation, global payment, episode-based, then you may want to think about the whole ball of wax, or at least review it in your roadmap.

So, next slide. I wanted to again point out that this is not particularly prescriptive and I would encourage all of you, and in just a moment I'll give you the links, to look at this framework carefully. But as you think about it, I started here with some suggested feedback and discussion points. And I think the one that's most important for us is for policy development, how and at what level we want to think about policy. I had already suggested that maybe we'd think about the primary HIT requirements, are there some use cases there that we could perhaps tee up from an ACO perspective that the S&I Workgroup could work on? Is it possible that we could look at some of the existing certification criteria and think about how useful they actually are in the clinical arena for the ACOs and think about are there ways they may be changed going forward? I think there are a number of ways that we can think about policy, using the framework, but it will require everyone to look at it a little bit more carefully than I can suggest in these last few moments.

So the next slide, which is our last slide, tells you exactly how to get to it quickly and easily. It came out yesterday, it's available on the health affairs blog and it's there, there's a link to it, it's in that blog article, which will not only let you see it, but the blog also is a place where we are looking for public comment, public feedback and open discussion. So hopefully we'll be seeing some public comments there. It's also directly available at CCHIT at the website listed here, so you can access it directly there as well. And I again encourage you to do so and if in any size, shape or form it can help inform our discussion going forward, and then it has met one of its objectives. So, I think we have about two or three minutes left, I'm sorry Charles, it was really quick, but hopefully maybe we can pick this up again another time.

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

Yeah, I think there's a lot of very rich information here that would be worth our while to delve through in greater detail. But, we are out of time and I believe we need to open the lines up for any public comment very briefly, is that correct?

Public Comment

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

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

Well wonderful. Look we, I think that was a lot of good discussion, probably could have used a little bit more time, but I want to thank members of the subcommittee for listening in and participating. We will get together at our next meeting, I think we've covered enough of the basic material that we can begin to start diving into some of the policy recommendations that we might want to bring forth to the HIT Policy Committee. So thanks everyone for participating, I hope you have a wonderful weekend. I look forward to speaking with you at the next call.