

**HIT Policy Committee  
Accountable Care Workgroup  
Transcript  
February 20, 2014**

**Presentation**

**Operator**

All lines are bridged with the public.

**Michelle Consolazio – Federal Advisory Committee Act 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 HIT 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 this meeting is being transcribed and recorded. I'll now take roll. Charles Kennedy? Grace Terrell?

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

Here.

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

Hi, Grace. Alex Baker, from ONC?

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

Yup, here.

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

Bill Spooner? Cary Sennett? Craig Brammer? David Kendrick? Eun-Shim Nahm?

**Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor and Program Director for Health Informatics Specialty Program – University of Maryland School of Nursing**

Here.

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

Hello.

**Eun-Shim Nahm, RN, PhD, FAAN – Associate Professor and Program Director for Health Informatics Specialty Program – University of Maryland School of Nursing**

Hello.

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

Frank Ross?

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

Frank's here.

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

Hi, Frank. Grace – I'm sorry, Westley Clark? Hal Baker?

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

Present.

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

Hi, Hal. Irene Koch? Joe Kimura? John Pilotte? Karen Bell?

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

Here.

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

Hi, Karen. Mai Pham? Sam VanNorman? Scott Gottlieb? Shaun Alfreds? Okay, with that, I'll turn it back to you Grace.

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

All right. Well welcome everybody and we have obviously been getting a lot of work done over the last several months, between the public hearing as well as the draft document that we've seen, those of us on the committee, and been commenting on. And what we hope we'll be able to do today is to actually coalesce around that document with all the comments that we've shared with one another, so that we can move forward with something that we can get ready for presentation.

So let me just – you see on the slide that's in front of you right now that remember that our workgroup charge was to have a set of recommendations on how ONC and HHS can advance the health IT capabilities for various accountable care arrangements. And we've looked at it from – the workgroup, from multiple value-based payment models, both public and private, not just the Medicare shared-savings or the value-based purchasing programs that are governmental. We are really wanting to focus on how to support a common set of core health IT capabilities that are broadly relevant across these arrangements. And realizing that there are issues with both specificity to particular situations as well as a need for interoperability that is sort of a constant focus of potential complexity as we move forward with whatever recommendations we have.

And then we've basically been focused on identifying recommendations that will align with both business and clinical imperatives. And would not likely rise spontaneously from the market alone and would be able to be something that could effectively have federal levers to be able to – where it could actually be something that the federal government could use to actually impact change. So within that context and those framing statements, I believe on the next slide we'll get down to business, if you could go to the next one, which was some reviewing principles for us to think about. And I'll just ask these questions, we've all sort of seen them, I think, in paper form before the meeting today, ask for comments and then let's get deep into the individual sections.

So, let's just ask them. Which of these recommendations do you consider out of scope or low priority? Is the recommendation clear and actionable? Does it impose or minimize administrative burden on either the provider or vendor communities? Is implementation a short-term, medium-term, or long-term effort? And that's very similar to a lot of our early conversation and really again, focusing much on the themes of the CCHIT framework we looked at previously, in that sort of context. To what extent does it enhance an already existing effort? Is its value in the ACO environment clearly stated? Are these recommendations organized correctly? And what is missing? So, I'm going to stop there and ask for any other comments from committee members about whether this is ringing true, and are we ready to dive into the details?

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

Grace, this is Karen. I think this is the list of questions that was sent to us when we got the list of recommendations in its draft form. And I'm wondering if it might be worthwhile to have just a little bit of discussion about how we would actually frame a principle. For instance, I'm a little bit lost in terms of my own thinking in it – with respect to the implementation being short, medium or long-term effort, and I don't know whether the rest of the group would think that it's important that it be short-term effort, medium-term, long-term or maybe that's not relevant to the discussion. So I'm just wondering if it is – if you think it might

be worthwhile just to have a discussion around some principles rather than the questions themselves.

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

Okay, well let's do that then. So within the context of the principles, from a scope or priority standpoint, that would make sense in terms of prioritization. I don't know that that's a principle with exactly the same types of problems that sort of the context of short-term, medium-term or long-term has, or, what are your thoughts on that? I mean, do you think we're ready with what we've all seen – does the committee think we're ready to start thinking about scope and priority? Do we have the ability to do that at this point?

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

Well I was thinking, I'll just sort of pick up again and then leave it to everyone else. But I was thinking along the line that a high-priority one would be one that is clearly actionable with some form of well-articulated federal lever. A lower priority one would be one that is sort of general, but something that really the federal government can't do easily using its – all of its policy levers, whether it's legislation or even just guidance. So that would be one. Then maybe a second one would be assuring that the value that we think we'll get out of the recommendation is going to be significantly greater than the administrative burden. So that could be another principle. So I was thinking more along those lines that a high-priority recommendation would fulfill some of the principles that we were thinking about when we asked the questions, but we didn't really articulate very well. So maybe I'm counting angels on the head of a pin, and if I am, I apologize to everyone. But, I'll – so was that – sort of that was my thinking on this.

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

So in terms of the first question, out of scope I guess has to do within the context of the federal levers in the – I saw that as sort of being different than priority. For example, there may be something that's very high priority, but which might ought not to be part of federal policy because the markets going to take care of it. Whether or not that's true, we'd have to look at each individual thing. For example, health information exchange, the interoperability, some of these things do not seem to be happening as rapidly as everybody has apparently wanted them to because the market clearly hasn't done that yet and so that may be a high priority for the federal policy. On the other hand, if it were to suddenly be a market solution or it had been a market solution, and then it may not have – I mean it seems to me that there's a difference between scope and priority.

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

This is Hal, I would agree with that. I think we have, over time, developed this idea of kind of a multidimensional magic quadrant. And I'm not sure what factor you take that up to, but where the ability to have an impact, the ability to not happen spontaneously through the industry, the ability to be driven by regulation effectively without creating unnecessary administrative burden and unintended consequences of compliance without achieving the mission all come together. That's the sense in which I'm looking at these things where they can move things forward and they're the most highest value of administrative effort from the federal government combined to the value it drives in improving healthcare. So I think Karen's on the right tact here, I'm just not sure we can draw it quite as well out as Gartner Magic Quadrant type illustration.

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

Hi, this is Frank. I – one of the things that kind of jumped out at me as I was getting prepared for this was, we haven't talked a lot about conflicting regulations and we talk about principles and we talk about what are the things that we're trying to steer toward and what are the things we're trying to steer away from. Something as simple as the changes in HIPAA that took place back in September, which forced everybody to go into kind of a scramble to make sure that their BAAs and everything were in alignment with HIPAA, has – that's a conflicting regulation, to a certain extent.

I don't know if it's within the scope of our recommendation to talk about trying to eliminate some of the roadblocks that are constantly being erected against ACOs, in terms of being able to obtain information. I know even in this presentation there was concern in here about making sure that we protect the right of the patient to approve the use of information. If you go to the Final Rule, the Final Rule's very – spent an elaborate amount of time justifying that we don't have to obtain consent. And that's why we're doing informed consent at the ACO level, we're not getting explicit consent to be able to obtain information, but at the same time, the way that we have to go about doing informed consent is a nightmare.

So, I think conflicts are important, too. I don't know if that fits in the scope of what we're trying to ferret out here or not, Grace, but I think we have to think about that as we make recommendations that can't be implemented because there's other regulation out there that's going to conflict with it, so –

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

Hal here, I think Karen did a nice job of illustrating some of that concern right before the meeting around behavioral health and it's critical role in managing accountable care –

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

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

– and yet some relatively antiquated legislation. I guess, well, I'd be interested to hear whether Frank and Karen's concerns are really meaningfully addressed by this group and the group it reports into or those are really outside of our purview.

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

Alex or Kelly, this is Karen. Is it fair to include concerns outside of technology as part of the purview of our workgroup, if it impacts significantly on how technology is used in the ACO environment?

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

Hey, sorry, Alex. I was on mute. I think that before we do the final version of these recommendations for the committee, we're going to need to vet those internally and just talk to Paul at the Policy Committee level about what he thinks would make the most sense to bring forward. But at the same time, the charge for our group is very broad, intentionally so, so that we're not restricted to just what is in ONCs immediate purview, but also because we want to use this as an opportunity to speak to other federal partners. So clearly, technology broadly is an important element, but I think that as we're thinking about what we'd like to say, we should think more expansively about that.

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

Thanks Alex. This is Karen again. Sort of just wrapping up a little bit of this conversation, like some of the other things that everyone's been talking about with respect to some of the key principles, not just the fact that it's actionable at the federal level, but also that its representative and was a market failure. And one of the last things I was thinking about is in terms of prioritization. The federal aims are increased quality, decreased cost and population health, so it would seem to me that a high priority recommendation might be one that's clearly articulated with respect to how it will support at least one of those three things. So I just throw that out as another principle. Grace, are you on mute?

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

Yeah, no, I'm looking at the – I'm not on mute, I'm musing. I'm looking over the recommendations, the review principles on the slide and thinking about the con – the discussion we were having. In my own mind, I was thinking, if these are what we agree to, and it may or may not be that. If we almost had like a grid with the recommendations, and then we had these questions, where we could sort of go through and day, 1, 2 and 4 are pertinent here, or whatever that might be useful in terms of going through it. Because frankly when I look at these questions, I like them, I think that they do sort of get contextually at some of the complexity of how we're trying to go forward with this. But, that's sort of what I was doing. I am here.

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

Okay.

**Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA**  
So how shall we proceed?

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

I would suggest we start looking at the specific recommendations and I'm not sure exactly what our evaluation and prioritization scale might be we might do some sort of like or numeric of –

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

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

– feasibility and impact rating. But I think we did that on several recommendations.

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

Yes. All right, well with everybody's consensus, let's proceed to the actual recommendation list then. All right, here was the first one, Meaningful Use measure for accountable care, which was that the future iterations of the ACO models should continue to maintain and expand provisions encouraging IT and health information exchange commensurate with increased adoption for health IT and basically linking it in with Meaningful Use. And there were a couple of comments that 2012 attestation should be qualifiable. And someone else said it needs to be an ongoing element. Is there anything in any of this that would be suggestive of some of the concerns we've had in terms of either increased complexity, difficulty for the ACOs, administrative burden or is this just something that's kind of a no-brainer?

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

Hey, this is Alex; just want to make a quick suggestion for people looking at this, because I know this is pretty small. If you click the full screen button on the WebEx, if you're looking at the WebEx, it makes it a lot easier.

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

The one point, Grace, I was concerned about is whether the last sentence is that we want 50% of participating primary care physicians to have attested for Meaningful Use Stage 1 at some point in the past. Or to be actively attesting for whatever subsequent stage is at the time they're coming in, Stage 3, Stage 4, whatever it may be, because the – with the rising stages, the administrative burden gets higher.

**Grace E. Terrell, MD, MMM – President and Chief Executive Officer – Cornerstone Health Care, PA**  
Sure does.

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

And I think there are some people who may opt out after Stage 2 or 3 because they just can't do it, got portal requirements for some of my community taking care of the Amish, it's pretty hard to comply.

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

Well even my non-Amish community is awfully hard to comply right now, why people just are – our portal is not as welcomed as we would like it to be among some of our population.

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

But – so somebody who'd gotten to all of Stage 1 or two years or three years might be an adequate requirement versus require perpetual participation. So I know we have the word both "by" or "in" each year here, I think we should be clear.

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

What does everybody else feel about that?

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

Hi, this is Frank. We kind of just pulled 50% out of the air and stuck it on there, I think. And I think in light of the 2012 report that was released, the benchmark report that was released recently, nobody's going to be able to qualify for 50%. I mean there may be some ACOs that are former IPAs or large group practices that are – or have enough centralized control to actually compel their providers to be Meaningful Use, but I'd say the vast majority, particularly ones like the one I'm involved with, a rural ACO, and we hit about 24% is what we hit. And so I – Meaningful Use has to be tied back into it, but from an ACO perspective, there's almost a dis-incentive because they – the Meaningful Use as a measure actually is double-weighted, so if you don't attest to Meaningful Use, you're providing a double burden, not just a burden but a double burden on the ACOs and organizations. So I'm a little bit mixed on it.

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

Frank, the second weighting being that you're not able to report data and participate in any kind of data warehouse?

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

No, the double weighing is the points assigned to the measure, I mean –

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

Okay.

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

– there's a point system, and I won't get into the whole thing, but there are four domains and there are points in each domain. Each measure is two points except for Meaningful Use –

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

Sure, okay.

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

– and that's...again, it's punitive. And I understand that somebody probably came up with that idea as a way to incentivize people, but if they thought that double-weighting the points in an ACO model was going to be incentive, when people are struggling to become meaningful users, it's – that just doesn't make sense to me. So, I think we've got to say that Meaningful Use is the pathway, it certainly provides, you've heard me say this in our conferences before, it's well over 50% of the measures, if you're a Meaningful Use attested provider, you're already hitting over half the bullets for reporting purposes, not for performance, but for reporting. And we've got to tie those two together, but I'm not sure saying 50% is a way to do it.

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

So –

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

And I would –

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

– go ahead, sorry.

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

Hal here again, I just think it would be extremely hard to be successful as an ACO long-term without direct data feeds and still working off paper and manual abstracting, because of the cost of trying to do that and get your meaningful handle around your population.

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

Yeah and with Stage 2, Stage 3 and beyond, it's going to get worse, Hal, it's not going to get easier, as you've already stated.

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

Sure.

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

Frank, would this be reasonable, a little bit more reasonable from your point of view if instead of requiring 50% of the primary care physicians to have done at least Stage 1, maybe we should just leave it at Stage 1, if we keep it. But the other option would be having them at least have ONC certified EHR technology, so they have the technology, maybe they haven't done everything with it yet to get to Meaningful Use, but they at least have the technology.

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

You know, coming up with a certified EMR, EHR is everybody's got them, half of them can't do it even though they're certified, so that's my comment about that. But I will say this, there are so many contradictions that providers talk to me about every day. One of them is, first of all, they all get PQRS certification, just by participating in an ACO that did successfully report. So they got a check, they got a check, which is the only check they've gotten so far, by the way.

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

I get that.

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

As PQRS certifiers, and by the way, these guys never did do that anyway, the ones that were reporting, we only had a couple of practices that were actually actively trying to report and receive PQRS reimbursement, but they did it because they weren't Meaningful Use and they were trying to avoid the penalties that were coming down the pike. So there are all kinds of misdirected signals being sent. If we're going to give people certification for PQRS just because they're a member of an A – a successfully reporting ACO, not performing, but reporting. Okay; then why wouldn't you do that – why wouldn't you say the same thing, why wouldn't they get something similar to Meaningful Use or actually Meaningful Use under a different classification, ACO Meaningful Use, if they are part of an organization that successfully reports. So, consistency is the key, doctors aren't stupid, they like consistency, they like to be treated consistently the same way. And those, even though they were overjoyed about PQRS, even though it was only one-half of 1%, they're not overjoyed about the fact that my ACO actually saved money, but we're not going to get any of it.

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

You know, I think there's one other way to look at this, too and that has to do with the fact that going back to the presentation we heard on December 5 that the average investment that an ACO has to make is above – north of 2 million dollars. And the Shared Savings that's likely to come is going to be very dependent, frankly, on Meaningful Use. So in many ways it's almost, another way of looking at this is that if CMS requires at least 50% of participating primary care physicians to attest for Meaningful Use Stage 1, in many ways a group that can't do that is being protected from investment that they might not be able to recoup as an ACO.

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

I think that's reasonable, Karen. If we said just the people have attested for Stage 1 Meaningful Use and that they have done that at some point in the past, whether it be the year of the ACO or before, I think that's a reasonable floor. Because you may be wasting your time if you're trying to do an ACO effectively with no EHR in any of your practices. But on the other side, there are probably enough extrinsic and intrinsic motivations of the ACO to keep people moving forward on their own, at least that's my thought.

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

Yeah, and I see this more as a protection for those ACOs, and we all know that a lot of them have lost money. We know the Pioneer ACOs had some major problems and this looks a little protective to me. So that was just my thought.

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

So where do we go from here? What are we going to do to this to get it where we're all in consensus?

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

Are we – does anybody disagree with the idea of 50% of participating primary care physicians have attested for Meaningful Use Stage 1 by the first year of the ACO participation? Right, does that sound like a reasonable floor ceiling that would protect somebody from trying to do this in an analog world?

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

Again, I guess the question would be, if they don't hit 50%, what happens?

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

Should they be trying, I guess is the question.

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

I think they're all trying. Remember though, the cost of Meaningful Use is on the back of the provider.

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

Yeah.

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

They don't get any money from us, from the ACO for doing that. And by the way, if they're late starters, if they just started in 2012, they're not going to get the full benefit in. By the way, what you get to do it doesn't really cover your cost.

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

No.

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

It just doesn't do it.

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

So if you don't have 50%, say you're 25 at the moment, you might want to wait a year before you apply and then begin to get more and more of your physicians engaged in Meaningful Use. So that by the time you do sign a shared savings contract, there's a high degree of likelihood that you at least won't lose any money on it and you might actually recoup some.

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

There is one little caveat though, that everybody needs to be aware of, we can't even find out – even though we know we had 12 practices that met Meaningful Use, we asked who were they, and the answer came back from the shared savings group that we can't find out. So here we go again, we're kind of lost in the dark here, because we asked all of our providers on the front-end, are you – have you either attested for or are you in the process of preparing to attest for Meaningful Use and you know what they all said, sure. But we get no solid information back from CMS about who actually successfully attested, and I did ask that very specifically. So, it's tough guys, trying to manage a group of physicians.

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

Well this may be one of those ones where the – a hardcore numerical legislative approach may not be as good as just the business wisdom of the task requires a certain amount of information flowing in exchange.

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

Yup.

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

And maybe we just view this as very good advice, but not something that should be codified.

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

No, if the application process to CMS to become an ACO had a feedback mechanism where a perspective list of providers could be presented as potential members of an ACO and then certain pieces of information could be fed back to the organizing group, then they would know that they either had providers that were Meaningful Use or not. But at this stage, it's a lost cause trying to figure that out.

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

This is Alex. I know something that we talked about in the past in discussions about this was maybe it's not for an application bar, but maybe it's after the first year of the program as more of a milestone type of thing. I don't know if that's helpful.

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

Okay. Let's move to the next one then I think we've sort of got that, actually, it's even just – that was just part one of one, so here's planning elements in accountable care program applicants. As part of the application process, CMS should require applicants to describe their plans to establish an IT infrastructure to support clinical integration, care coordination, including the focus on steps that they will take to exchange clinical information with behavioral health and long-term post-acute care providers. Karen, you sent something out earlier, I was in clinic and did not have a chance to review, but was it partly talking about some federal efforts around behavioral medicine? Is this relevant here?

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

Actually, you're right, it was around behavioral medicine, but it's not relevant here –

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

Okay.

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

– it's more relevant in sharing information, so we'll get to it later.

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

Okay. Pertinent to the conversation we just had about trying to encourage people to move along with IT infrastructure, I mean, to my mind, this one is sort of a mom and apple pie, there's nothing that makes it anything but good for an applicant to be considering how they might solve or think about IT infrastructure for their ACO. So, it's one of those, who can be against that. Other benefits, administrative burden, and it didn't seem to me that actually just planning should be considered in that context. So then, we get down to scope, and there were several comments about concerns about the feasibility of some of this.

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

This is Karen; I'm going to just jump in for a minute because I think one of the things that would be very helpful when we make these recommendations is also to suggest that when appli – in the application process, there is inclusion of references where people might go to do this sort of thing. So very specifically thinking about behavioral health clinical integration, SAMHSA has a lot available on that, it's done some work with the National Council on the different types of behavioral integra – behavioral health clinical health integration that can occur. So if we're going to do something like this, we might just want to get some good references.

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

Sounds good to me, no objections here.

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

I agree, I think we just want people who are thinking they might be able to move forward without considering these two areas to have a pause moment and have a clear contemplation of how critical they are.

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

Exactly. And if they have some place where they can – references they can look at, well what does this really mean. Again, I think I keep coming back to these being protective of programs and provider groups who really aren't ready to take on financial risk just yet, and giving them an opportunity to think about what they need to do to get there.

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

It's a general balance between being prescriptive enough to prevent people from having needless failures that undermine the whole initiative and being so prescriptive that you suppress the opportunity for somebody who's truly creative and has figured out a better way to do this.

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

Yeah, and I think this is – this one does maintain that balance pretty well, so I am very supportive of it.

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

I would agree. However, we couch the final exact language, we just need to make sure that it's not an opportunity more for vendors and consultants than it is participants.

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

Um hmm.

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

There's always somebody with any new language that tells you that they have the way to advise you on how to write these applications and what not and can take a piece of – or actually increase the expense without necessarily increasing the value. So I think it's going to be important that from a standpoint of clarity and scope, that it's – it does not overly worsen things, but has our intentions with where we want to actually go. It's almost a checklist type of thought process, from my standpoint.

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

Good point.

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

So the next portion of this, incentives for non-Meaningful Use eligible providers. This is really getting again to the point that there are a lot of folks out there, behavioral health providers, LTPACs and others who are really not part of the current Meaningful Use eligible providers that may or may not be the focus of how we actually write this, since we're now just talking about Stage 1 for primary care. So given our previous conversation, do we keep this in there, is this the right place for it. Someone said let's strengthen it. How – with our comments on subsection (a), how do we want to think about subsection (c) here?

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

My concern is that so many long-term post-acute care facilities don't really have a meaningful EHR record yet and penetration into a lot of behavioral healthcare, especially non-MD behavioral healthcare of EHR is pretty limited, especially considering the privacy restrictions on therapy notes, putting them on computers isn't always advantageous.

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

Yup. The other side of that – in our ACO is that we have a real black hole other than just claims data about, from a care coordination standpoint, about the long-term care facilities in our area. And of course, behavioral medicine, that's just always a problem for various reasons we're all familiar with. And so digging through the claims data that we get back from Medicare Shared Savings and then trying to figure out how to partner with particular long-term care facilities and it's difficult, particularly if they have no motivation on their part to really be part of a system. So if it becomes a mar – if the ACOs are really successful in the future and everybody wants to be the facility partner of an ACO, then it may be a market solution anyway, but right now it's certainly not.

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

Correct me if I'm wrong but section (c) is we're talking about providers outside the domain of Meaningful Use.

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

Yes.

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

Yeah, we're talking about the folks that Meaningful Use didn't intend to do anything with in the first place. And I like what's being said there, I think the idea is a good idea, but there's very little guidance about how do you bring those people into the fold. Maybe the expansion of Meaningful Use to provide all aspects of the healthcare community, regardless of how far down the thread they are, may be an appropriate thing to get people to start thinking about it. Because the providers we have, yes, they come under Meaningful Use as an ACO, or they can if they attest, but at the same time, look at all the other healthcare providers in the community that aren't even part of it. And that's part of the rub, because we've got requirements to exchange information and we've got other healthcare providers out there that we cannot exchange information with because they're not in that fold, they're just not in the domain.

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

Frank, you know that brings up a point for me in that last sentence, where it says, “these funds,” if we were to go ahead with this recommendation, “can be used to further support investments in developing an HIT care coordination infrastructure with these critical partners.” But it doesn’t say these funds “must” or “should be” used and I think my concern is that if we’re going to be expecting, as you say, LTPAC, behavioral health providers to be able to exchange clinical data with clinical – with physical health or primary care, whatever. Then there needs to be some way to get some financial support to them to do that and this could be one way of doing it, but if it’s just that the funds “can be used,” every ACO is going to look at this differently. And some of them probably will use that money to – with their – long-term post-acute care partners and behavioral health partners and I suspect a lot of them won’t. So I think if this is really going to meet the need of helping to support other providers to engage in clinical data exchange, it needs to be a little bit stronger about how further investment support can be used.

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

I totally agree. I has to say at least, these funds “should” be used, if – must be used would be a better phrase, I think. Because if you don’t do that, that funding can trickle off into other endeavors that don’t meet this criteria at all.

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

So let me throw out an opposing view, we’re talking about meaningful clinical exchange of data with part of the industry – healthcare industry that’s not really tied to MU and it may have much lower penetrance of the EHR. Is that maybe a 300 level course to go back to college and we need to do the 100 level course of getting meaningful data exchanged between Meaningful Use certified EHRs before we try to put a requirement out on the group that’s probably a second or third tier objective, after the infrastructures been mastered? That’s meant to be provocative.

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

By all means, please be, I think a little provocation is necessary if we’re going to make headway. One of the things that I’ve come to learn as being part of an ACO, versus running a primary care practice is that there are a lot of providers out there that I deal with every day that have absolutely no IT capability, period, because they’re not part of this domain.

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

Right.

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

They’re not part of this Meaningful Use effort. And I specifically, I mean we’re talking about home health. Home health is a very large cost component for CMS, but that is the Wild West when you’re dealing with home health agencies, because they can’t exchange information. So I guess I’m trying to throw out the potential here that when I talk to developers, when I consult with people about what products do I think would be useful, our ACO has developed everything that we are using right now on our own, with funds from CMS, but still, we’re doing it on our own. And I know that there are markets out there that would develop if there were funds available or there were requirements in place that said, look, as an ACO you have to figure out how to manage this care coordination.

Care coordination is the real challenge and if you have to manage it then you could possibly provide the technology to your home health agencies in your locale, and be able to effectively engage them in doing a better job for – of accountable care. Now, there’s a lot of detail that goes into that kind of discussion, I’m not going to try to bring that up today. But again, the concept of a domain, Meaningful Use domain, broadening that domain not necessarily to say that everybody has to rush out and buy a Meaningful Use certified EMR, because EMRs don’t work in certain care settings, they just – they aren’t applicable. And I think we have to understand that and when we make recommendations, we have to understand that Meaningful Use doesn’t necessarily have to be what we call it today as being bound up in a proprietary EMR.

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

And in fact, using the language of population health management tools or analytics rather than EMR may kind of get us out of that mindset.

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

That's a great idea. I like that.

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

I have to say – this is Karen again, as much as I love the idea of finding a way to get funding to long-term PAC and behavioral health to bring them along from an HIT perspective, I'm wondering if the administrative burden and everything else that goes along with it is a little bit too much, with this particular recommendation. So I'm kind of beginning to think we have to find another way to get money to LTPAC and behavioral health.

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

Well, if the ACO burden goes back – if the burden goes back on the ACOs and they have no power over the other providers –

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

Yeah.

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

– then that's going to be the problem, sort of to Frank's point all along. Although all of us, to his other point, really wish we had this so –

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

So I guess the question is, are we trying to stimulate the marketplace through the providers or is there a way that we can directly motivate the technology partners to these areas of care to really embrace techno – exchange, that's a little bit of a chicken or the egg.

**Craig Brammer – CEO – HealthBridge**

Hey folks, it's Craig Brammer here, just listening along and jump in here. Has there been consideration of certification just around standards? I mean, the core problem here is that those vendors that service that part of the market don't conform to standards definitions and ontologies, so is there perhaps a certification program, even with no money attached, something that might apply a little pressure to that vendor space?

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

Yeah, this is Kelly Cronin. We have another – the Certification/Adoption Workgroup is actually working on that issue right now, about for the scope and how might we shape and launch a voluntary certification program for LTPAC and behavioral health. We got a lot of public input and support of that last year, and now we're – we are trying to think, how do we do that? The focus initially will be on interoperability and then there are other needs that might be specific to those settings that have to be addressed, maybe on a glide path.

But there are other considerations under way about how we to tie it to other financial incentives and programs, such as LTPAC and behavioral – or LTPAC and home health value-based purchasing. But I – there, accountable care is an important avenue to address, too. So I think it might take multiple levers across Medicaid, Medicare and other payers and we want to be open about everything at this point because it's a large universe of 16,000 skilled nursing facilities and other post-acute settings and home health that are going to require a lot of support.

**Craig Brammer – CEO – HealthBridge**

Good. Well I think, you're unique – I mean Kelly, you think about this all day long, so you thought of this a year ago, but I think you're at a unique spot now where when MU came out, nobody really knew what certification meant or the implications of it and whether it was going to stick or whatever. And now I think if you introduce or expand certification to non – to different delivery settings, you've got some momentum going and I don't think you necessarily need to put as much money behind it.

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

And this is Karen. I would just add that some – among the recommendations that we still will be going through down the line, is one that very specifically talks about certifying all types of HIT around very important interoperability standards. So, as Kelly said, you start with interoperability and pretty much think about any type of technology that is being used in the care setting, and that would probably help the market a great deal.

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

Hi, this is Frank again. I always lean toward market; I guess you guys figured that out a long time ago.

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

Really?

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

Yeah, I mean I think the market's going to – when you want creativity; the market's where you go. But, one of the things that did come up in the discussion we had recently in an open group was the idea of ACO partner. Some sort of certification where healthcare providers in the community could be certified as an ACO partner and funds could flow to them either through the ACO or directly from CMS, as long as they met certain certification requirements. Now I know that's kind of a – that's a giant leap in faith that there are ACO standards, but there are, I mean the actual measures themselves call for the – define the standards that we need for exchange of information. I think that's a strong way to go, I don't know if it's within the scope of the current recommendations that we're trying to do. But I think when we talk about (c) on this slide in front of us right now, I think we're kind of punching around the edges of that very idea or how to get these outliers, or get the ones that are not Meaningful Use domain committed to actually participate in this ACO experiment.

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

Well, speaking of moving along, shall we try to get to maybe number two on the discussion today? So this is when we get into a lot of the access to administrative data, which has been a theme we've had for a long period of time. On the first sub-part of that, it was about strategy for scalable data architecture, and we've had alternative language that was proposed and then some comments about the alternative language. And so where are we with, as a group, in sort of going through this?

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

Well this is Karen; I'll jump in again. Since I proposed the initial alternative language, I'll explain a little bit why I did so. The – I'm aware that there are all payer claims databases in 13 states right now, and in many of those states, that is not available to the ACOs. So my hope was, in crafting some alternative language, was that the states who have them and the states that are moving towards them, and a lot of states are doing so, do that in a way that accomplishes three things. Number one, it is economy of scale, so every ACO doesn't have to create its own integrated database. Number two, does it under a set of uniform methods and quality control standards and number three, does require that any state that's receiving funding to do this, have commitment from Medicaid and private payers. And also somewhere along the line it might have fallen off here, that there is the agreement that they would provide that information to the ACOs themselves. So, I think that last point may have fallen off on my alternative language, but I did very much want to include that requirement that provider groups at risk for specific patients must have access to claims data on those patients. So you would have – you would meet the needs of the ACOs, you would have economy of scale and you would have an effort that is backed by some uniform methods and quality control.

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

Karen, this is Kelly, those are all great points. And I just also wanted to raise the issue of, when we think about trying to scale something nationally, which I don't think we're that close to figuring out. Other than having sort of the Qualified Entities Program, having those entities across the country that can have access to data, and it's through the Medicare Shared-Savings Program, obviously having the monthly feeds. But in terms of multi-pay – a scalable architecture for multi-payer claims where we have really good geographic coverage, it doesn't – we're not quite there yet, but if we think about the evolution of accountable care going from sort of maybe individual provider networks to one that's going to become more maybe community-oriented over time.

As models like the state innovations model and accountable care communities from the Innovation Center start to sort of take people away from just individual ACOs to thinking about how do we scale something across the medical neighborhood or communities so that we have much more integration. I wonder if we do need to be mindful of thinking about the scalable architecture beyond a given ACO, so that we can – the payers and everybody who has to sort of feed into this, have a rational system where they're getting sort of standard formatted, clean data where it needs to go at the right time. And if it's always going to be sort of one off trying to get the data out from multiple payers, it's going to be really complicated.

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

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

So I think there is a need to be thinking about sort of the broader data architecture to support it in addition to meeting these sort of near-term business requirements for individual ACOs that are managing at risk.

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

No, I would absolutely agree and I think that's why I had suggested my alternative language to fund a study to identify – that architecture, I didn't word it quite the same way, so maybe it does need to be reworded. But I think it's the same concept, we really need a uniform way of doing this.

**Craig Brammer – CEO – HealthBridge**

I would caution against using – this is Craig, caution against using states as the necessary definition and SIM as the necessary vehicle. So, I think it's that plus other mechanisms, perhaps, I'm not sure that –

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

Yeah, that's a great point and maybe it's regional data centers or something that we haven't yet completely crystalized, but there's got to be sort of more – some more deliberate thinking around geographic coverage.

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

Well the only think I would add to that is that there are obviously a lot of national payers, but every state has its own rules and regulations about payer – health insurance payers within each state. So it does become a state-based geography when you think about health plans and how health plans operate and that was the reason that these APCDs started at the state level.

**Craig Brammer – CEO – HealthBridge**

Most of them have been state-mandated, so – but yeah, I take your point, it's just that I just worry about the state demarcation as the de facto for some of this, because I think it's going to be multiple states in many cases.

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

Yeah, I agree.

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

And I think there's a difference between the transaction of payment, which can be intrastate, but the management of population, especially with the size ACOs need to come up to, and the high number of major geograph – residential areas that border a state border, is going to make it hard to do. I really do like the idea of getting some nomenclature, because even within a single system like mine, owning all the different product, it's very hard to get good data flow, largely because of the ontology problems and lack of data architecture.

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

One of the interesting things that's happening in the New England area has to do with the fact that there are currently APCDs in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut is now building one. And there's been some early discussions already going around in terms of a regional APCD, once each of these individual ones have been built. So, I think this issue of going beyond state is absolutely important. In the beginning, my own – but we have to start somewhere, so I think whether you start at the state level or you grant this to a region, I think it's a very important piece going forward. I just think about –

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

The other thing –

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

As well, just your dual-eligible patients, think about people who are on Medicare Part A, but their Part B is still through an employer. I mean, there are so many different ways that in order – you will need some sort of an all-payer database in order to really track the total cost of care of the patients for whom you are responsible.

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

This sort of goes back to the metaphor of the railroad I used during the hearings, which is, if we ever sort of get the railroad, there can be all sorts of utilization for different purposes, but we clearly don't have it built yet in any sort of functional way. I think this is absolutely crucial to everything going forward to a simpler, better health information enabled healthcare system.

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

Well, this is Frank again. Keep one thing in mind, too, the EDI infrastructure's in place. We've just recently signed an accountable care contract with Cigna as another line of business within our ACO and they're going to dump everything they've got on us. So the data is there, the challenge is, we've got to be able to figure out how to process it. But I think maybe the tracks are built, Grace, but we just don't have the authority to go to the payers and say, we want your data.

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

Well, even when you do, and I'm very familiar with that Cigna contract, among many others, there's not been any – not only is it an authority issue, but it's an issue of different ones with different approaches to how they're going to share information with you. And then what do you do from the standpoint of actually trying to manage an entire population as opposed to an insurance product related population, which has been part of our concern is being able to treat all of our patients in all of our contracts appropriately.

**Craig Brammer – CEO – HealthBridge**

So I have two other comments on this particular one. This is Craig, again. Let's see, one is, there's language, as folks probably know, in the proposed SGR legislation that is around the – it's specific to the Qualified Entity Program, but I think it's a good foundation for CMS contribution to APCDs. And in the absence of that passing, I wonder if there's a mechanism to get some of that through here or referen – tie those things together. The other question is, this is – Kelly, this is a question for you, but, this is, as I understand it, a unidirectional from purchasers – from carriers to providers and wonder about the – certainly the utility of being able to do certification essentially, of a third party to report back to carriers on behalf of the providers. Where does that fit in here?

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

In terms of measurement and performance reporting?

**Craig Brammer – CEO – HealthBridge**

Right, right, right.

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

Yeah, well, I think the clinical data registry is sort of the existing vehicle for that and then our certification of EHR modules would be relevant to make sure that the EHR derived measures are being calculated right. But I don't think that's sort of the end of the story, that as we move to longitudinal measures and other more transformational measures, it's likely going to be a revised form of certification. We did have a subgroup looking at accountable care measures and the infrastructure behind it; I think they're sort of wrapping up their work.

We could pass a question back to them around that, but I think the near-term answer is that it – if you're qualified as a clinical data registry, that you be able to report in to Medicare on those measures. And hypothetically, like in Michigan and elsewhere, what David Kendrick is doing in Tulsa, Oklahoma, he's got the payers to, as you know, to agree to accept the data. So they are, by default, sort of qualifying that third party to then submit the performance measurement. But right now, it's sort of a region-by-region negotiation.

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

These are all very good comments. Shall we move on to the next one? I've got a hard stop right at, when is it, 2:30, right when the call is supposed to be over and we are having great conversation today, but let's see if we can continue to move it forward, unless anybody objects. Everybody okay with that?

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

Yes.

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

Um hmm.

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

Okay. All right, so we're getting in to the availability of behavioral health claims in portion (b) here. We've all continued to talk about how important that is, and then it also the general thing, if you then go into (c) we could almost talk about these two together other than the complexity of the behavioral medicine one. And that the claims data is absolutely important in and of itself, not just for behavioral medicine, but for all these other sources we've been talking about. Karen again, I did not read your specific email, just because of my time constraints this morning. Is this where we need to talk about behavioral medicine, or are you just going to tell me.

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

I'll tell you, it's actually where we get to the information sharing. So this is really very specific to the behavioral health claims – and doesn't share.

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

Probably ought to pull up the email and just stop asking you, but, I don't – I mean, for years as a practicing internist, it's always struck me as being exceedingly bizarre that I can diagnose depression and treat it and it's not considered to be data that's not – that's just part of a regular medical record. But when somebody from a behavioral medicine background does it, it's considered to be taboo. Now what we've learned through the years in our own organization that has behavioral medicine is that a lot of the culture of prevention of behavioral medicine data is simply the culture. And not what's actually out there in the legislation or law, it's basically therapy notes that are off bounds rather than the actual information that is now available to ACOs. So I guess my thought process on all this is, what's actually real versus what everybody actually thinks is real when it comes to access.

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

I agree with you that many of the barriers are self-imposed and historic and not currently in the rules. And certainly we're moving faster than the law towards the idea of treating somatic and behavioral health issues as equivalent medical problems with parity and less stigma. But that's a generational change that's going to take some time.

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

But, within that context, would – rather than some regulatory response would some positive aspect actually be a culture – by that I meant a policy or something that essentially would be an incentive to sort of change that culture, as opposed to sort of a mandate be helpful?

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

Perhaps even just an affirmative statement that exchange of this type of information is not prohibited by federal law and is supported with references might be helpful.

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

Yeah, this is Karen again. I remember way back when, it was thought that Medicare release of any claims data was against the law. As time went on, the legal department within HHS, actually found a way to make that happen. And I can't help but wonder when it comes to claims data, it's not the actual record that –

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

Right.

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

– occur, which is I think what you were saying, Grace.

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

Yes.

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

It's not the actual record, so is there – I think the hope here is to maybe ask HHS' legal department to go back and really revisit this. And see if there is some way, in the same way they got around the release of regular clinical claims, if there's some way they might not be able to get around this one, too.

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

Perhaps somebody could shed a little light on the reason why those claims were initially available, but then withdrawn.

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

Yeah.

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

I mean, I never got a satisfactory explanation for that.

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

But it share was a pain in the rumpus around here because we had to – it created a tremendous amount of difficulty in terms of the way we do backups and what not, when they released those and then they went away again. It was a lot of work to comply with that.

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

You know I certainly know the Final Rule didn't make that happen, I mean, that was not precluded by the Final Rule. So I'm – I was very confused at the time and like you said, Grace, we had to back up and take another run at it, had to reprocess all of our data, again. And CMS had to redo it as well, so it was a big faux pas, it really was.

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

Yeah.

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

Well CFR 42 is very broad, but it's also very specific to substance abuse, so I'm really hoping that the recommendation here will direct, in some size, shape or form, HHS to really revisit the options that exist here, because I think that there can be some. But the community isn't going to – them on their own, they're going to look to HHS' legal team define them.

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

Yeah and I will just add as a specific example, Suboxone has proved to be a very awkward to try to read through this because a lot of primary care doctors help handle Suboxone and they otherwise use an electronic health records and do they need to carve it out, and that's been a point of a lot of discussion. It doesn't change our policy, but just an aside.

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

Let's face it, there's no information flowing at all right now and I guess the thing I see here is that we're looking to claims to be the first hole in the dyke. Other than claims, are there other recommendations that we ought to be making?

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

It sounds like there's consensus that we all would wish that we'd move towards more – along with insurance parity, we move to more information parity and we stopped carving out as much behavioral health and started to let that be treated and destigmatized.

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

Absolutely.

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

Um hmm.

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

Yeah.

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

Maybe that's as much a recommendation as we can make.

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

Let's move forward then, because I like that. The next one is just about claims availability in general. And so then if we go on to number 3 – which I think we already came to a consensus of and discussed early, so if we go to number 3, which is access to encounter data. The original text said patient event notifications, ONC should focus on developing a scalable architecture and implementation guides using HL7 standards and other modules, which would notify an ACO or primary care physician when a patient is admitted or discharged from the hospital. And it says many communities have HIEs that are successfully deploying this sort of alerting infrastructure, but there's a need for lower cost and easily deployable option that is not dependent on the availability of robust HIE infrastructure at the community level.

And one of the comments obviously, this is low-hanging fruit. And it looks like there is another comment that there are already some innovation fellows working on this. I want to draw this back to some of the comments in the public hearing about the hoarding of information that some people complained about within the context of rival competitors within the healthcare space. And even in our organization, we're on staff at multiple hospitals and we have ADT feeds from some and not from others and so is it really about the architecture alone or is it also going to be about the regulations around the necessity of doing this?

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

Hal here, if I had one gold star to put on one recommendation, it would be this one.

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

Yes.

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

I just have the feeling this might be the crack that opens up, has enough business drivers, enough reality, low enough stigma, easy enough to do, that it might start to create a pathway to which other information will flow.

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

And it's just the right thing to do for patients.

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

Absolutely. So I don't know if we can make this one bold, but –

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

Well, that does point to the fact that even though HHS has an innovative fellow working on this at ONC, I think it's really important that we include this as a recommendation, even if it's not going to lead to any significant change, just because it is so important.

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

Good.

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

Is that okay with you guys at ONC, Kelly and Alex? Does this help you at all?

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

Frank, I remember you were –

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

Yeah, no –

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

– strong on this also.

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

Yeah, no, I think that would be great to include this in here, especially given how much we've heard over the deliberations.

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

Okay, well let's move then. Next. Social determinants of health, to make an effort to understand the scope and issues related to making an integrated set of social determinants of health. There was some confusion from one of the commenters, about what this was talking about and others were commenting about establishing pilots that would figure out how to get to this information. It sounds like there was enough confusion that we need to sort of dig into this a little bit more. Who would like to start it?

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

Well this is Karen. Maybe I'll start this one. I think this has to do with the fact that everyone recognizes that it's the social determinants of health, what's happening in the social environment in what decisions patients make about themselves that determine 80% of their overall health, what we do in the delivery system, 20%. So accountability for overall health requires understanding a little bit about what is going on in people's lives outside of the delivery system. And when we talk about social determinants of health, we're generally talking about measures and data that actually exists already –

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

Yes.

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

– but generally at the state level. So it has to do with homelessness. It has to do with food subsidies, has to do with care that's been provided in correctional facilities, has to do with birth and death registries. There are a lot of information – or data, let me put it this way, there's a lot of data that's housed in federal agencies that is very much siloed and not accessible and it would all be considered part of the social determinants of health. And from a very practical example, if you're trying to manage a diabetic and suddenly they're not doing very well, and you don't know that they have become homeless and are living in a hotel room and eating take-out all the time, it's very hard to manage that patient.

So, the bottom line here that if we're going to do this, then we do need an understanding about what exactly are the elements in social determinants of health that would need to be included to better support health and that the ACOs would need to know about. So that's why you'd have to start with convening a stakeholder group and then we'd have find ways to drive collaboration among the stakeholders of all this data that exists in government agencies and bring it together. So it's actually a long-term process, it's not something that would be addressed right away. But once you did have the social determinants of health, not only could you use them to provide better care for your patients but secondly, you can also use them to identify patients who are really at risk and intervene before they begin a significant downhill course. So there are a couple of reasons that this is important, but it is a long-term effort, but again, if you don't start now, it isn't going to happen in a timeframe to be useful.

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

Well said and here, here on the siloed data that's already there that we were not talking to one another. It's already available. My only caveat to that is, are there any privacy concerns that will be raised within the context of going forward with this that we ought to just be thinking about now.

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

I am sure that there are, but that would have to be part –

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

Do we want the NSA data, for example? I'm going to be radical here, but my point being is that that is such a big issue right now at the level of sort of the public consciousness about fear of too much information at the federal level. And whether that's real or not I don't think is relevant, other than when people think about the right to privacy of data, and we're thinking about public health and the benefits of having it. As we move forward with how to integrate more and more data that's out there, now available, legal but is not integrated, how shall we do so in a way that feels appropriate to our citizens?

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

It's a rough line but there's a big difference between the care model, which pays us to treat disease, and a system that asks us to manage health and people in a population.

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

Sure.

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

An ADT feed is pushing the edge of where we are now, getting a notice from the IRS that somebody's paychecks had stopped coming or that they've been evicted or that they were arrested for drug-related charges, that would all be things you'd want to know if you were managing somebody's health, but boy that's going to push on privacy.

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

Yes.

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

But if we just start this in some direction, starting with a conversation and start inching into it, it seems very critical and I – absolutely what Karen says, that has become the most critical thing in us managing our super-utilizers is to recognize the social context where the people live and try to manage their disease. And sometimes non-medical treatments are the critical thing to disease care.

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

Hi, this is Frank. I wanted to make a comment, too, from a primary care perspective that instead of having carte blanche access, which is kind of what I'm sensing here, that we want to consolidate silos and we want to be able to transaction may go out and do queries on those. Wouldn't it be a little bit more palatable to consider that within HIPAA, there's already a provision where a patient can say, I give you, provider, my permission to go get information associated with me. It's pretty absolute, too, if you go back and read the rules. And I think that in – as long as you stick to that approach, where the patient has given not just informed consent, but actual consent, a written consent, to obtain information from whatever source, then you can possibly build a mechanism that would allow providers to gather information, as they deem necessary.

I mean most primary care providers know when their patients are having social-linked disorders, they know it; if they're not showing up, well they're not showing up so that tells you a problem right there. But if they're actually coming in and they're having problems, they know it; they just need to get the truth about what's going on instead of the information that's not always accurate. So, anyway, I just wanted to kind of throw that out.

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

The other way of potentially thinking about this is not also at the level of the individual, but, for example, a lot of the epidemiological data at the state level is looking at case rates of everything from heart attack deaths to STDs to premature births, at least what I've seen on the registries here in North Carolina. It is as I say, to the level – granular level of a zip code analysis, where we know where there are hot pockets and hot spots. So there are ways of actually thinking through this from a predictive modeling standpoint that maybe a way of doing it, which is, if you happen to have a patient and they're in a particular zip code that's at high risk for having particular problems, whatever they might be. That there is the ability to integrate that – those epidemiological data in with population health management tools such that it could be added for analytic purposes, maybe that would be a way to at least start with this without pushing too much on the privacy, per se.

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

One of the things that we might do, in terms of considering the recommendation itself is, obviously probably need to articulate this a little bit better than it is on the text. But to really point out that this truly is important going forward and that there are a lot of considerations that will have to be discussed that we wanted to set up the discussion and maybe even start by just doing the second thing. If you get a group of public health stakeholders together with some ACOs you – or some clinicians, you may be able to at least come up with a standard set of SDH elements that would be useful and then go from there.

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

Very good. Let's see, I have 2:25, I've got a hard stop at 2:30 and I – as most of you all probably saw the email from Charles that he was not going to be able to make the call today, so I've been chairing the discussion, we do need to open it up in just a few minutes for public commentary. This has been a great discussion today and I think we need to move it forward. Does everybody else have a hard stop, too, or is this something that we just need to stop at 2:30, as was previously announced?

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

We do need to stop at 2:30 because there is another Federal Advisory Committee call.

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

Okay. So it's 2:26 on my computer clock here, we've got four minutes. We've gotten through 3(b), I haven't – let me go to my other – what's next, are we all the way through the (b) yet? Go to the next slide please.

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

Medical neighborhood and then data liquidity.

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

Okay, so let's stop there and take this back up next time. I think that this has been extremely useful and should help us move forward with things and to go into this level of depth and thoughtfulness as we're moving forward with all of this is – does everybody else feel similarly or any suggestions for how we might do this differently next time?

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

Grace, I liked the idea you had about the possibility of a matrix. I know Alex is probably wanting to cut my throat for saying that, but I think if we put a matrix together and we applied the principles to that matrix, it may help. Because I – this is – I like what – the organization that's taken place, but I would like to see us try to focus in on the stuff that's really got the priorities.

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

Other thoughts?

**Craig Brammer – CEO – HealthBridge**

Yup, that sounds good.

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

Okay.

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

Grace, I just want to throw in just about the timing. So our next scheduled call is for March 20 and then we are hoping to present the draft version of this to the Policy Committee meeting that is on April 8, I believe. So I'm wondering I know people's schedules are rough, but if we should try to fit another call in there, where we could do the rest of this in this fashion and then do the prioritization process to arrive at what our final list is going to be, which we could ratify on the March 20.

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

It sounds very reasonable to me. Others?

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

Absolutely, I think we need the second –

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

That's fine.

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

– a second meeting.

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

I do, we may even want a second meeting to pick up where we left off.

**Craig Brammer – CEO – HealthBridge**

Yeah.

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

Yes.

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

Okay, well we'll try to figure this out internally about how we could make that work, but be on the lookout for some more information about that.

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

Just not that next week during HIMSS, that's all.

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

Yes.

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

Right, because that may well be –

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

Unless we all want to meet there.

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

Thank you. Thanks all.

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

Well I'm going to, other than the public comments, I'm going to conclude the meeting at this point and turn it back over to you all.

**Public Comment**

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

Thank you. Operator, can you please open the lines?

**Ashley Griffin – Management Assistant – Altarum Institute**

If you are on the phone and would like to make a public comment, please press \*1 at this time. 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. We have no public comment at this time.

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

Okay, well we look forward to playing calendar wars with one another so we can find another time to continue on with this good and important work and in the meantime, for those of you heading to HIMSS next week, safe travels.

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

Thank you.

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

Thank you.

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

Thanks Grace. Bye all.

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

Bye, bye.