Accountable Care Workgroup Recommendations Document
HIT Policy Committee – April 8, 2014, 12:30 – 1:30 ET

The descriptions provide additional detail and considerations on the draft recommendations being presented to the HIT Policy Committee on April 8, 2014. The charge of the Accountable Care Workgroup is to:

- Provide a set of recommendations to the HITPC regarding how ONC and HHS can advance priority health IT capabilities in a variety of accountable care arrangements to support improvements in care and health while reducing costs.

Detailed Draft Recommendations

I. HIT adoption and infrastructure. The availability of a robust health IT infrastructure is crucial to accountable care arrangements, but the required upfront investment is challenging for smaller providers. HHS should explore additional ways to incentivize and encourage providers that are preparing to take on risk under these arrangements to adopt HIT and information exchange capabilities that will help them achieve cost and quality targets.

a. **Strengthen requirements around the adoption of HIT for participants in more robust accountable care models (e.g. two-sided risk model under MSSP).** In future iterations of accountable care models offered through the Center for Medicare, the Center for Medicaid and CHIP Services, and the Center Medicare and Medicaid Innovation, CMS should continue to strengthen provisions encouraging providers to adopt and implement health IT and health information exchange for more robust risk models. As an example, CMS could consider a requirement that new entities applying to the program demonstrate that at least 50 percent of participating primary care physicians in a two-sided risk model have successfully attested for at least Meaningful Use Stage 1.

b. **Elicit additional detail around HIT infrastructure planning from applicants to accountable care programs.** As part of the application process for CMS and CMMI programs around accountable care, CMS should elicit descriptions of applicants' plans to mature along a path of increased accountability and the development of an HIT infrastructure supporting their participation in new models, e.g. from initial investments in clinical integration across the continuum of care and care coordination to future capabilities around management of more robust financial risk models.

c. **Expand the Advance Payment Model within the MSSP permanent program.** The advance payment model is a critical strategy to help providers in accountable care organizations finance the HIT infrastructure needed to succeed within these models. CMS should act to formalize and expand this program.

d. **Provide additional shared savings incentives to accountable care organizations that include partners who are not eligible for EHR incentives.** In order to support IT infrastructure development with critical partners who have not received subsidies under the EHR incentive program, CMS should establish provisions within the Medicare Shared Savings program under which ACOs can receive incentives in the form of additional

shared savings for partnering with entities such as LTPAC, behavioral health, and home health providers. ACOs would then use these funds to further support investments in developing care coordination infrastructure with these partners.

II. **Access to administrative and encounter data.** Providers operating under accountable care arrangements are striving to obtain access to existing but inaccessible electronic data that will allow them to manage the total costs of a defined population of patients. HHS should continue to demonstrate leadership around expanding the availability of administrative and encounter data residing in different silos and driving greater uniformity and scalability so that this data is made available in usable formats.

   a. **Encourage the development of state-level all-payer claims databases to support accountable care arrangements (inclusive of Medicare & Medicaid).** ACOs need to calculate total cost of care on a given patient, assess the overall cost effectiveness of their care coordination and care management programming, conduct predictive modeling, run attribution algorithms, determine the costs of "keepage/leakage," and conduct financial analyses to determine how managing their risk patients affects their overall financial health. HHS should use state-level mechanisms (e.g. SIM funding) to support the development of APCDs and ensure that Medicaid and private payers doing business in that state are contributing data to an all-payer claim database or other identified entity, as well as ensuring that APCDs make data on their attributed patients available to provider groups taking on financial risk. A uniform quality assurance methodology to assess the reliability of claims integration processes should be independently developed as part of this program.

   b. **Explore mechanisms for facilitating the flow of behavioral health claims data and other sensitive data that are subject to additional privacy protections to ACOs and other providers.** ACOs have expressed a strong interest in being able to receive behavioral health claims as part of the information they receive from Medicare in order to effectively deliver comprehensive care to patients who receive these services. ONC and SAMHSA should explore development of mechanisms that facilitate the flow of this information subject to additional privacy protections.

   c. **Make Medicare eligibility and benefit determination data on attributed patients available to accountable care organizations to ensure providers aware of patient health needs.** HHS should consider requiring Medicare contractors to make information about real-time queries of Medicare eligibility and benefit determinations available to providers participating in accountable care programs, either directly or to a centralized repository.

   d. **Develop and disseminate a scalable model for delivering timely electronic patient event notifications to concerned providers supported by admission, discharge, and transfer feed data.** While many communities with HIEs have successfully deployed patient event notifications built on admission, discharge and transfer feeds from hospitals, there is a need for a lower cost and easily deployable option that is not dependent on the availability of robust HIE infrastructure at the community level.

HHS/ONC should continue to develop a scalable architecture and implementation guides using HL7 standards and other re-usable modules which will notify an ACO when a patient is admitted or discharged from a hospital and provide technical assistance funding to disseminate these tools.

e. **Drive progress on standardization and capture of social determinants of health data elements that are most critical to accountable care delivery models.** Healthcare stakeholders must work towards inclusion of a broader set of information of community and social inputs that are critical to effective care delivery, beyond clinical information alone. HHS, through the State Innovation Model (CMMI) or another channel, should develop an effort to understand the scope and issues related to making an integrated set of social determinants of health (SDH) available for both patient care and for planning/research purposes. This effort should build on existing efforts (e.g. current initiatives led by the Institute of Medicine) in considering the following activities:
    a. Convening public health stakeholders and providers to focus on determining a standardized set of SDH elements, considering different use cases, e.g. most critical data sought by ACOs.
    b. How to drive collaboration between stakeholders including Medicaid, social services agencies, and other sites where SDH data resides; and
    c. Establishing pilots under CMMI which would focus on the capture and sharing of social determinants of health data to inform how future policy directions can support access to and availability of this data.

III. Exchanging Data across the Healthcare Community. Patients assigned to one accountable care provider organization may and do seek a significant amount of care elsewhere. Ensuring that institutions are sharing data for treatment purposes is particularly important to providers and patients in accountable care arrangements. HHS should use available levers to incent information sharing by all health care institutions.

a. **Set expectations that hospitals and health systems participating in federal accountable care models must participate in health information exchange activities.** Future requirements for the Medicare Shared Savings program should include an expectation that participating hospitals will engage in health information exchange with all community providers to the degree that relevant technology options are available. At a minimum, hospitals could be expected to make standardized electronic admission, discharge and transfer feed to community partners.

b. **Specify within hospital survey and certification standards that institutions must electronically transfer discharge summaries to treating providers in a timely manner.** CMS should update hospital survey and certification guidance to state surveyors to include assessing the degree to which hospitals send electronic discharge summaries in a timely manner to the treating provider regardless of affiliation with the hospital.

c. **Increase public transparency around hospitals and health system performance on measures related to health information exchange.** HHS/ONC should explore public reporting options that would measure the degree to which hospitals and health systems

are performing on specific measures around exchange, for instance, reporting of Meaningful Use transitions of care measure results through inpatient quality reporting on the Hospital Compare Web site.

d. **Issue additional guidance around sharing of information protected under 42 CFR Part 2 across participants in an accountable care organization.** SAMHSA should consider issuing additional guidance to specifically address issues relevant to providers in the ACO environment in order to help further reduce misconceptions and variations in interpretation that persist among providers. For instance, SAMSHA could offer guidance on how ACO entities that include substance abuse facilities might establish QSOAs across participants with an administrative relationship to permit sharing of clinically relevant information or the conditions under which primary care providers conducting SBIRT services are considered Part 2 providers.

IV. Data Portability for Accountable Care. Providers in accountable care arrangements must aggregate and manipulate data across a wide range of systems to support a comprehensive view of the patient, deliver seamless care coordination across settings, and manage populations of attributed patients. HHS/ONC should continue to use available levers, such as the health IT certification framework and related standards development priorities to drive interoperability across EHRs and facilitate integration across different HIT tools supporting an accountable care ecosystem.

a. **Pursue greater specificity in federal interoperability standards around transactional data.** Increasing availability of structured data is critical to accountable care infrastructure. ONC should continue to develop more specificity in federally recognized interoperability standards to promote semantic interoperability and seamless flow of information across systems. ONC should increase specificity around transactional data such as discrete HL7 data feeds for admissions, discharges and transfers, notifications, labs, prescriptions, etc., as well as further specification of continuity of care document standards.

b. **Strengthen data portability elements in certification criteria.** Develop testing procedures that demonstrate the technical ability to not only send discrete data points in a recognized, structured, and consumable manner, but also receive and make data computable within a receiving application.

c. **Develop future certification criteria to promote access to EHR data by other types of HIT systems to support population health management, operations, financial management, and other uses.** ONC should implement standards being developed under the Data Access Framework (an S&I Initiative) around a common API for HIT applications which would allow real-time sharing of information between applications. A future voluntary certification which would allow participating vendors to demonstrate that they can easily integrate with other applications.

d. **Increase availability of data from remote monitoring devices to engage patients more deeply in their care.** Integration of data from remote monitoring devices into EHRs and other platforms is critical to ACOs seeking to reach patients outside of traditional encounters. ONC and FDA should review barriers and related issues linked to the use of

patient focused remote monitoring devices payment, certification, quality, satisfaction, and how data from these can best be made available to the clinicians of record.

V. **Clinician use of data and information to improve care.** Organizations operating within accountable care models must develop systems that support clinicians' ability to deliver effective synchronous and asynchronous care to patients by providing tools that deliver a longitudinal view of the patient, access to evidence-based guidelines, and other information.
    a. **Create a task force to accelerate the development and adoption of standards-based electronic shared care plans across federal programs.** The HIT Policy Committee should assign a task force to make recommendations on how to define electronic care planning; what policies, standards and programs are needed to support asynchronous and synchronous care planning; how care team members including the patient/caregiver can adopt a shared process for developing and exchanging electronic care plans; and a roadmap for shared care planning in the short and long-term that builds upon existing and emerging federal and state policies, standards and programs.
    b. **Develop pilots to test different shared care plan models.** Granting agencies (CMMI/AHRQ/HRSA/etc.) should establish new initiatives/opportunities to pilot and test best practices for Shared Care plans that would support a market-based adoption of such tools.
    c. **Improve the impact of clinical decision support (CDS) tools by measuring effectiveness.** More research is needed into when CDS is effective in informing clinician decision-making, e.g. the breadth of data needed to deliver effective decision support.
    d. **Increase the sensitivity and specificity of CDS algorithm tools by encouraging standards that will support the incorporation of comprehensive data from multiple sources.** A key use case for ACOs around CDS is the ability of external data to be integrated with data in the EHR so that it can trigger a specific and sensitive algorithmic driven CDS alert. More work is needed around how to get to this functionality. The HITPC should prioritize development and certification of standardized functionality within EHRs that would enable consumption of external data to incorporate into and trigger clinical decision support.

VI. **Streamlining the administration of value-based programs.** Organizations participating in accountable care arrangements and other delivery system reform efforts are facing a significant burden associated with documentation and reporting to federal, state, and commercial entities implementing accountability mechanisms associated with these programs. The administrative burden of reporting multiple measures to multiple organizations in different formats detracts from an ACO's ability to use HIT to adopt clinical quality improvement processes that will lead to sustainable improvements in the overall process of providing care.
    a. **Align quality measures across all relevant HHS agencies and with private payers.** HHS should hasten its efforts to standardize all measures required by its various agencies, departments, and programs, and continue to support efforts to align these measures with other payers so that all unique and relevant measures can be calculated and

submitted once by a given provider to a single location, thus eliminating the need to report performance measures to multiple payers in multiple formats.

b. **Articulate HHS' future strategy around the infrastructure needed to integrate claims and clinical data to support accountable care.** Integrated claims and clinical data across participating payers and providers will support less burdensome reporting of quality metrics and improved specificity of predictive modeling. HHS can advance progress toward these objectives by articulating and supporting a strategy for qualified entities (e.g., all payer claims databases (APCDs), regional health collaboratives, health information exchanges etc.), that will enable research and development of integration processes in support of these and other ACO specific use cases.

c. **Develop and promote a common standardized methodology and approach to attributing patients in the ACO environment across all payers and providers.** HHS should work with other payers and providers to develop a consensus driven standardized algorithms for attribution patients to a particular ACO that can be used by all payers and providers.

d. **Develop standards for administrative procedures to reduce variation in provision of care for ACOs and other providers.** The HITSC should consider development of or building upon standards for administrative procedures associated with the provision of care. Examples include prior authorization for medication and procedures, referrals for care, and certification requirements regarding necessity of care imposed on attending physicians in the hospital setting.

e. **Conduct a review of current regulatory burden on providers.** The HITPC should task a workgroup to review and evaluate the efficacy and burden of all of the CMS documentation requirements for each patient encounter within the health care system and make recommendations to CMS regarding which are important for patient care and which represent mostly administrative burden.