**Accountable Care Workgroup Final Recommendations Document
Presentation to the HIT Policy Committee – July 8, 2014**

This document provides a detailed summary of the final recommendations of the Accountable Care Workgroup of the HIT Policy Committee. 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.

*Final Recommendations*

The Accountable Care Workgroup has identified the following high priority recommendations across 5 focus areas:

1. **Exchanging Data across the Healthcare Community**
2. **Data Portability for Accountable Care**
3. **Scaling the Data Infrastructure for Value-Based Programs**
4. **Clinician Use of Data and Information to Improve Care**
5. **Streamlining the Administration of Value-Based Programs**

As described below, each of the focus areas below includes:

* *Background:* A brief statement about the rationale for why the Workgroup is focused on this topic, current challenges ACOs are experiencing in this area, and existing efforts that Workgroup recommendations seek to build on.
* *Strategy Statements:* Key overarching themes that the Workgroup would like to see guide future work in this area.
* *Priority Recommendations:* These recommendations represent high priority opportunities to advance work in the focus area. Some represent immediate opportunities to benefit providers working in accountable care arrangements, while others are more likely to impact providers in the medium or long term but require increased attention now.
1. **Exchanging Data across the Healthcare Community**

*Background*

Patients assigned to one accountable care provider organization 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, yet today, strategic, technical and financial considerations are inhibiting exchange of data. In addition to increasing exchange of information among “core” providers such as hospitals and health systems, providers in accountable arrangements must be able to electronically exchange data across the broader continuum of care with entities such as long term care facilities, behavioral health providers, and community service providers that are crucial partners in the care of many high-cost/high-risk patients.

*Strategy Statements*

1. HHS should set expectations that providers, particularly hospitals and health systems participating in federal programs, are sharing information broadly with partners to improve the quality and safety of care across settings.
2. HHS should promote consistent requirements across different policy levers around how providers should complete timely exchange of data using standards-based exchange methods during patient transitions of care.
3. HHS should identify additional mechanisms to support HIT adoption among those providers who are ineligible for the EHR incentive program and have not been able to make adequate investments in modernization.
4. Exchange of behavioral health information across providers is critical for ACOs focused on high-cost/high-risk patients. SAMHSA and ONC must continue to 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.

*Priority Recommendations*

* + - 1. **HHS should 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. At a minimum, hospitals could be expected to make standardized electronic admission, discharge and transfer feeds available to community partners.
	1. **Increase public transparency around hospital 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 (potentially coinciding with a mature Stage 3 measure in 2017) through inpatient quality reporting on the Hospital Compare Web site.
	2. **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.
	3. **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 clarify the conditions under which primary care providers conducting SBIRT services are considered Part 2 providers.
	4. **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). HHS, through CMMI, should also consider establishing pilots to 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.
1. **Data Portability for Accountable Care**

*Background*

The information infrastructure needed to support providers in accountable care arrangements must be flexible and scalable across networks and capable of: aggregating data across a wide range of systems to support a comprehensive view of the patient; delivering seamless care coordination across settings, and managing populations of attributed patients. ACOs seeking to establish platforms for population health management across multiple systems are acutely experiencing interoperability challenges, yet they lack the leverage to drive vendors to implement solutions to these issues. While implementation of Meaningful Use Stage 2, as well as proposed changes in the 2015 certification rule NPRM are likely to promote progress on these issues, additional evolution around the standards and certification framework will make it easier for ACOs to build the infrastructure they need to truly succeed within these models.

*Strategy Statements*

1. Future certification standards for EHR technology should seek to promote greater access to clinical data stored in EHRs by other applications to reduce obstacles for providers seeking to innovate around the IT infrastructure supporting population health management.
2. ONC should focus additional attention on discrete data standards, in addition to further constraining document based data standards, in order to effectively promote interoperability across systems.
3. ONC certification criteria should demonstrate greater attention to ensuring systems’ ability to successfully ingest data.

*Priority Recommendations*

* + - 1. **Increase access to EHR data by other types of HIT systems to support population health management, operations, financial management, and other capabilities.** 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 could allow participating vendors to demonstrate that they can easily integrate with other applications.
	1. **Pursue greater specificity in federal interoperability standards around transactional data.** The 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 look for immediate opportunities to 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.
	2. **Strengthen data portability elements in certification criteria.** Lack of confidence around the ability of HIT systems to receive and ingest data, despite being certified to send data, is a major challenge for accountable providers seeking to coordinate care. ONC should expand testing procedures for certified EHR technology that require products to 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.
1. **Scaling the Data Infrastructure for Value-Based Programs**

In order to succeed in value-based care models, ACOs need to bring together a number of different data sources in an integrated fashion to inform business and population health management strategies. ACOs must calculate the 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 at-risk patients affects their overall financial health. Ultimately, ACOs need to be able to integrate this information with clinical data to fully understand how to maintain and improve quality while decreasing costs. ACOs have begun to gain experience in these areas, for instance, through the claims data feeds shared with participants in the Medicare Shared Savings Program. However, administrative data across payers remains inaccessible to most providers, hampering their ability to fully understand the cost of care for attributed patients, and the infrastructure for delivering this data remains nascent or inconsistent across communities.

*Strategy Statements*

1. 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.

*Workgroup Recommendations*

* 1. **Articulate HHS’ future strategy around the infrastructure needed to integrate claims and clinical data to support accountable care.** Integrating clinical data with claims, cost, and price data across participating payers and providers will support less burdensome reporting of quality metrics, increased capacity of providers to improve quality and reduce costs, and improved specificity of predictive modeling. HHS can advance progress toward these objectives by articulating a strategy for how the federal government will engage with the various qualified entities capable of receiving and aggregating these data at the local, regional, and state level (e.g., all payer claims databases, regional health collaboratives, health information exchanges etc.). This strategy should support: research into and development of integration processes that support a range of specific ACO use cases, mechanisms to ensure accountability and reliability of integration processes, and mechanisms for ongoing monitoring and evaluation of participating entities.
	2. **Encourage the development of state-level all-payer claims databases (APCDs) to support accountable care arrangements (inclusive of Medicare & Medicaid).** HHS should use state-level mechanisms (e.g. SIM funding) to support the development of APCDs, ensure that Medicaid and private payers doing business in that state are contributing data to an all-payer claim database or other identified entity, and ensure 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.
	3. **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.
1. **Clinician Use of Data and Information to Improve Care**

*Background*

Organizations operating within accountable care models require tools that support clinicians’ ability to deliver effective synchronous and asynchronous care to patients and engage with other clinicians and providers across virtual, interdisciplinary care teams. While the meaningful use of EHRs provides an important foundation, providers in accountable arrangements have additional needs around advanced health IT-enabled care tools and processes to accelerate gains in quality and efficiency. For smaller providers, the required upfront investment in a robust health IT infrastructure capable of meeting these needs is especially challenging.

*Strategy Statements*

1. HHS should pursue opportunities to support the evolution from paper-based to electronic processes for care management and care coordination required across federal programs.
2. HHS should support the adoption and effective use of tools that shift providers away from traditional medical models toward holistic approaches to patient care based on the participation of all care team members, including patients and caregivers.
3. CMS/CMMI programs focused on delivery transformation must continue to highlight HIT/HIE adoption as a fundamental capability for providers seeking to engage in advanced payment models.
4. HHS must continue to seek ways to help providers invest in the robust HIT infrastructure necessary to support accountable care models, especially those with limited options to finance this infrastructure.
5. Providers within ACOs need access to actionable measures that address both quality and cost in order to make informed decisions in the value-based care environment.

*Workgroup Recommendations*

* 1. **Accelerate the development and adoption of standards-based electronic shared care plans across federal programs.** Building on existing standards for care planning, the HIT Policy Committee should assign a task force to make recommendations around how to drive further adoption of electronic shared care planning by: defining the policies and programs needed to support workable models for asynchronous and synchronous care planning; how virtual, interdisciplinary care teams, 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.
	2. **Develop pilots to test different shared care plan models.** Granting agencies such as CMMI, AHRQ, HRSA, and others, should establish new initiatives to pilot and test best practices for shared care plans that would support market-based adoption of such tools.
	3. **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.
	4. **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.
	5. **Expand the Advance Payment Model within the MSSP permanent program.** The Advance Payment Modeloverseen by the Center for Medicare and Medicaid Innovation has proved an important demonstration of how to support provider investments in health IT to support care coordination, through a share of future streams of shared savings payments and is an important model to continue to expand.
1. **Streamlining the Administration of Value-Based Programs**

*Background*

Organizations participating in accountable care arrangements and other delivery system reform efforts face a significant burden associated with documentation and reporting to federal, state, and commercial entities implementing accountability mechanisms associated with these programs. Streamlining this process is critical to the development of multipayer accountable care arrangements needed to impact quality and cost of care delivered across a provider’s entire practice. Moreover, administrative burden can detract from ACOs’ ability to adopt clinical quality improvement processes that will lead to sustainable improvements in the overall process of providing care. HHS/CMS has expressed a strong commitment to a “report-once” approach to measurement reporting which will evolve through different initiatives to align programs across the government.

*Strategy Statements*

1. HHS should continue to explore ways to accelerate toward the vision of standardizing all measures required by various agencies, departments, and programs, 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.
2. HHS must ensure that this work includes and is aligned with efforts by private payers to increase efficiency for providers across commercial populations as well.

*Priority Recommendations*

* 1. **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.
	2. **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.