**Draft Accountable Care Workgroup Recommendations Document – March 18, 2014**

*Workgroup Charge:*

* 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.

*Review Principles:*

1. There is a clear Federal policy lever that can be applied to move the recommendation forward.
2. The desired outcome is not likely to be accomplished under current market conditions.
3. The value of the initiative significantly outweighs any administrative burden imposed on providers or vendors.
4. It has clearly articulated value with respect to improving quality, managing costs, and/or population health
5. The recommendation is likely to have near-term impact or is a significant long-term priority.

*Recommendations for Consideration Overview:*

1. **HIT adoption and infrastructure.**
   1. Strengthen provisions in accountable care programs (e.g. MSSP) that incentivize providers to obtain health information technology.
   2. Request additional detail around infrastructure planning with respect to HIT from applicants to accountable care programs.
   3. Expand the Advanced Payment Model within the MSSP permanent program.
   4. Provide additional shared savings incentives to accountable care organizations that include partners who are not eligible for EHR incentives.
2. **Access to administrative and encounter data.**
   1. Develop a strategy and vision for scalable data architecture to support accountable care with integrated claims and clinical data.
   2. Provide access to claims data for prospective Medicare ACOs.
   3. Provide access to behavioral health claims data for Accountable Care Organizations.
   4. Make eligibility and benefit data available to support accountable care organizations.
   5. Drive progress on standardization and capture of social determinants of health data elements.
   6. Further clarify federal guidance around protected information to increase sharing of behavioral health information.
3. **Exchanging Data across the Healthcare Neighborhood.**
   1. Articulate expectations that hospitals and health systems participating in federal accountable care models must participate in health information exchange activities.
   2. Increase public transparency around institutions’ participation in health information exchange. **(CONSIDER REMOVING)**
   3. Include electronic transfer of data within hospital survey and certification standards around discharge summaries.
   4. Include patient event notifications in the objectives as part of the Meaningful Use program. **(CONSIDER REMOVING)**
   5. Develop a scalable model for patient event notifications. **(CONSIDER REMOVING)**
   6. Develop guidance to facilitate exchange of protected data within ACOs.
4. **Data Liquidity for Accountable Care.**
   1. Drive greater specificity and structure in interoperability standards.
   2. Encourage EHR functionality that allows for greater provider customization of workflows.
   3. Increasing access to EHR data and improving portability of data across systems.
   4. Strengthen Meaningful Use measures for cross-vendor exchange. **(CONSIDER REMOVING)**
   5. Increase availability of data from remote monitoring devices.
   6. Increase effectiveness of certification tools.
5. **Clinician use of data and information to improve care.**
   1. Accelerate progress on development of shared care plans.
   2. Incentivize care plan usage. **(CONSIDER REMOVING)**
   3. Coverage and eligibility data at the point of care.
   4. Clinical decision support efficacy.
   5. Claims data at the point of care. **(CONSIDER REMOVING)**
6. **Administrative Simplification.**
   1. Reporting simplification and measure alignment.
   2. Administrative procedures.
   3. Review regulatory burden.

*Detailed Recommendations:*

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| *Original Text* | *Comments for Discussion* |
| 1. **HIT adoption and infrastructure.** The availability of a robust health IT infrastructure is crucial to accountable care arrangements, the required upfront investment is challenging for smaller providers. HHS should explore additional ways to incentivize and encourage providers that are taking on risk under these arrangements to adopt HIT and information exchange capabilities that will help them achieve cost and quality targets. |  |
| * 1. **Strengthen provisions in accountable care programs (e.g. MSSP) that incentivize providers to obtain health information technology.** 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 maintain and strengthen provisions encouraging providers to adopt and implement health IT and health information exchange commensurate with increasing adoption of health IT. For instance, CMS should consider a requirement that new entities applying to the program demonstrate at least 50 percent of participating primary care physicians have successfully attested for at least Meaningful Use Stage 1. | May not be MU that is critical to success as an ACO, but PCMH team structure with an EHR (with latest interoperability standards), having the latest edition of ONC cert beyond 2014 is less crucial.  To successfully implement this provision, HHS may need to share data on the MU attestation status of prospective members with the ACO organizing entity. |
| * 1. **Request additional detail around infrastructure planning with respect to HIT 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 develop an IT infrastructure to their participation in new models. Plans should provide sufficient detail and articulate a glide path for infrastructure development, e.g. from initial investments in clinical integration and care coordination to future capabilities around management financial risk. Applicants should also describe steps they will take to exchange clinical information with behavioral health and long term/post-acute care providers. |  |
| * 1. **Expand the Advanced Payment Model within the MSSP permanent program.** The advanced 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. | Many commenters have noted that recommendation below seems to be getting ahead of current provider priorities given continuing difficulties in establishing exchange infrastructure with core partners. Could be addressed through a statement in support of broader expansion of the Advance Payment Model. |
| * 1. **Provide additional shared savings incentives to accountable care organizations that include partners who are not eligible for EHR incentives**. In order to support 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 participating 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. Depending on availability, incentives could be tied to forthcoming certification programs geared toward specific providers. | Operational details will need to include a good definition of “partnering” and how to monitor use of funds. |

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| *Original Text* | *Comments/Major Revisions* |
| 1. **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 data residing in different silos and driving greater uniformity and scalability so that this data is made available in usable formats. |  |
| 1. **Develop a strategy and vision for scalable data architecture to support accountable care with integrated claims and clinical data.** HHS should initiate an effort (possibly within the State Innovation Model program) to define best approaches to aggregation of claims and clinical data and articulate a strategy to develop a scalable data architecture which can serve the needs of providers, health systems, states, payers, and other stakeholders engaged in accountable care arrangements. This effort should focus on:    * 1. Coordination across many organizational types that can act as repository and aggregator (e.g. qualified entities, regional quality data intermediaries, organizations supporting health information exchange, and all-payer claims databases) to serve the needs of providers seeking comprehensive clinical and administrative data to support value based purchasing and quality improvement at a local, community, state, or regional level.      2. Technical challenges around integrating claims and clinical data and establishing uniform methods and standards for integrating claims data across multiple sources that can be disseminated across models.      3. Exploring mechanisms to encourage commercial payers and other entities to share claims data with their ACO partners.      4. Facilitating the availability of data enclaves that combine Medicare and commercial data and that can be used for discovery and research (not direct patient care). |  |
| 1. **Provide access to claims data for prospective Medicare ACOs.** CMS should make Medicare claims data available to providers that are contemplating development of an ACO in order to allow them to evaluate the financial risk associated with their attributed patients in advance of participation in the program. |  |
| 1. **Provide access to behavioral health claims data for Accountable Care Organizations.** CMS and SAMHSA should work to overcome existing barriers to the release of Medicare Behavioral Health Claims to providers participating in accountable care programs. | The lack of access to behavioral health claims continues to be a challenge for providers seeking to understand comprehensive care patterns for their patients. The ACWG statement would urge HHS to reconsider release of this information. |
| 1. **Make eligibility and benefit data available to support accountable care organizations.** Access to eligibility and benefit data is an important channel to promote timely awareness of patients’ health needs so that these providers can guide patients to settings and services that best align with their patients’ benefits and the settings and services available within the ACO itself. 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. |  |
| * 1. **Drive progress on standardization and capture of social determinants of health data elements.** 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 consider:   2. How to drive collaboration between stakeholders including Medicaid, social services agencies, and other sites where SDH data resides; and   3. Convening public health stakeholders to focus on determining a standardized set of SDH elements, considering different use cases, e.g. most critical data sought by ACOs.   4. 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. |  |
| * 1. **Further clarify federal guidance around protected information to increase sharing of behavioral health information.** Inconsistent interpretation of CFR 42 Part 2 persists among providers with respect to sharing of data by substance abuse facilities covered under Part 2, posing a significant challenge for ACOs seeking to manage costs for high-risk patients across the continuum of care. SAMHSA, OCR, ONC, and CMS should work together to review CFR 42 and make recommendations | WG noted intense need to change the ways we think about behavioral health data, including language about what data would be appropriate, e.g. therapy notes ought to be restricted, but diagnoses and medications could be shared in a way that makes sense.  EHR certification could also focus on segmentation—as the Certification and Adoption WG is exploring. |

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| *Original Text* | *Comments/Major Revisions* |
| 1. **Exchanging Data across the Healthcare Neighborhood.** Patients assigned to one accountable care provider organization may and do seek a significant amount of care elsewhere—care for which the providers are financially responsible under accountable care arrangements. While moving between settings patients, their families, and providers should expect to have consistent and timely access to standardized health information that can be securely shared. In order to better coordinate and direct care, providers need actionable information regarding where and when their patients are admitted, discharged, or transferred from other care settings (emergency departments, hospitals, LTPAC, etc.) While this information may ultimately become available through claims or other channels, providers need access to timely information to impact care. |  |
| 1. **Articulate 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. |  |
| 1. **Increase public transparency around institutions’ participation in 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. This could entail reporting transitions of care measure results included in as part of inpatient quality reporting on the Hospital Compare Web site. | **Consider removing:** May not have sufficient impact to warrant inclusion. ONC could follow up on this or other tools separately if it is not necessary to include in these recommendations. |
| 1. **Include electronic transfer of data within hospital survey and certification standards around discharge summaries.** CMS should update hospital survey and certification guidance to state surveyors to include send electronic admission/discharge/transfer notifications and electronic discharge summaries in a timely manner to the treating provider regardless of affiliation with the hospital. |  |
| 1. **Include patient event notifications in the objectives as part of the Meaningful Use program.** ONC should include patient event notifications as an objective under either Meaningful Use Stage 3 and establish new certification criteria to ensure an EHRs can generate a real-time HL-7 ADT data feed. | **Consider Removing:** This may not be appropriate for inclusion in Meaningful Use, as feeds are already available for meaningful encounters such as ER, Hospital, etc. |
| 1. **Develop a scalable model for patient event notifications.** While many communities with HIEs have successfully 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. ONC should continue its current efforts to develop a scalable architecture and implementation guides using HL7 standards and other re-usable modules which will notify an ACO or primary care provider when a patient is admitted or discharged from a hospital. | **Consider Removing:** This recommendation describes current program work ONC is doing. Other recommendations focused on ADT feeds may suffice to convey the WG’s interest in identifying notifications as an important strategy. |
| 1. **Develop guidance to facilitate exchange of protected data within ACOs.** SAMHSA should consider whether ACOs and their participants could be treated as a single administrative entity to permit sharing of protected information with substance abuse facilities, or how ACOs could develop a model in which participants multiple QSOAs to facilitate sharing of protected information. |  |

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| 1. **Data Liquidity 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. |  |
| 1. **Drive greater specificity and structure in interoperability standards.** 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. |  |
| 1. **Encourage EHR functionality that allows for greater provider customization of workflows.** ONC should prioritize development of standardized functionality within EHRs that would allow for customizable triggers within the workflow for providers to insert tools and directives. | This could potentially build on similar work being conducted within the structured data capture initiative that is part of the S&I Initiative. |
| 1. **Increasing access to EHR data and improving portability of data across systems.** The HIT Policy Committee should consider options to implement standards being developed under the Data Access Framework (DAF) to develop a common API for HIT applications which would allow real-time sharing of information between applications. The HIT Policy Committee could then consider how these standards could be initially implemented as a part of future voluntary certification which would allow participating vendors to demonstrate that they can easily integrate with other applications. |  |
| 1. **Strengthen measures for cross-vendor exchange.** The HIT Standards Committee should strengthen measures around cross-vendor exchange for meeting HIT Policy Committee and HHS objectives around transitions of care in future stages of Meaningful Use. | **Consider Removing:** Cross-vendor exchange may not be the right way to approach this given problems with measurement and implementation. This measure is no longer proposed in MU Stage 3. |
| 1. **Increase availability of data from remote monitoring devices.** ONC and FDA should review barriers, and issues related beyond, 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. | 1. \*ADDED RECOMMENDATION\* 2. The HITPC has recently done work on this topic, recommendation would be to highlight importance of this work for accountable care models. |
| 1. **Increase effectiveness of certification tools.** The HIT Standards Committee should direct ONC or another HITSC workgroup to consider activities that build upon or complement the current certification process to increase vendor accountability for effectively implementing interoperability specifications. This group could consider several different mechanisms including: | As we move beyond ONC CEHRT 2014 we need to be careful about how EHRT is defined. Goal should be to exchange critical data among multiple HIT platforms, products, and product types. This means a clear focus on interoperability, which is under the aegis of the HITSC. |
| 1. Developing an “accreditation” or “recognition” program for vendors who have demonstrated the ability to efficiently and easily share data across systems and within population health management platforms in practice (i.e. beyond demonstrating interoperability under controlled conditions). | **Consider eliminating this concept:** 1) The market will quickly figure out which vendors are truly willing to play in the interoperability space without yet another government run program (and all that this entails) 2) There is currently NCQA accreditation, ONC certification, KLAS recognition, etc. Another recognition program may not bring much value, but would certainly add to burden and costs. |
| 1. Developing a more robust system for monitoring performance of certified products’ ability to effectively implement exchange in practice, e.g. through a system for identifying customer complaints, with an option to place vendor certification in a provisional status if identified concerns are not addressed. | **Consider limiting this recommendation solely to transparency:** While concept is important, difficult to effectively tie it back to certification. The problem is that a vendor could meet the certification requirements to the letter while not really effectively supporting exchange in practice.  Could this be assessing how well customers do at ‘using the exchange’? Certification can be technically compliant but practically unusable. |
| 1. Developing additional testing procedures that demonstrate the technical ability to not only send data in a recognized manner, but also receive and make data computable within a receiving application. | 2015 Voluntary NPRM includes measure around EHR capacity to receive CCDs. |

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| 1. **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. |  |
| 1. **Accelerate progress on development of shared care plans.** The HIT Policy Committee should task a workgroup or tiger team to make recommendations on how to define electronic care planning; what policies, standards and programs are needed to support asynchronous and synchronous care planning; and how care team members including the patient/caregiver can adopt a shared process for developing and exchanging electronic care plans. Key areas of focus include: 2. Developing a roadmap or trajectory for shared care planning in the short and long-term building on what is optimal for the patient/caregiver while considering existing and emerging policies, standards and programs. 3. Identifying an agreed upon term for the electronic care plan and the processes by which interdisciplinary care teams may develop, update, exchange and access the electronic care plan. 4. Determining the impact of these electronic care plan exchange processes on workflow and system rollout across provider settings. 5. Identifying the governance strategies and implications for curating, managing and maintaining an electronic care plan. | **Consider additional recommendation:** promote granting agencies (CMMI/AHRQ/HRSA/etc.) in testing/piloting best practices for Shared Care plans that would support a market-based adoption of such tools.  **Suggest that we need to make a recommendation to meet the more immediate need for shared care planning.** Should we support or comment on the need to build on the HL7 Functional Model? Once there is at least a basic model for a SCP, then users will include it in their workflows in the most effective way for them. |
| 1. **Incentivize care plan usage.** For a future stage of Meaningful Use, consider an objective that providers must collaborate in the management of a common, patient-centered shared care plan for a specified portion of patients with chronic conditions. | **Consider removing:** this should probably not be an MU requirement for the simple reason that once the technology is available and the payment incentives are aligned, the provider community will be incentivized to do this in the name of good patient care. Adding a requirement to the federally sponsored incentive or penalty program will not add value, but would be considered administratively burdensome. |
| 1. **Coverage and eligibility data at the point of care.** ONC should explore standards/Meaningful Use objectives to promote the availability of coverage, eligibility and benefit data at the point of care to assist clinicians in making informed decisions about costs and referrals. | **Move recommendation:** Should be covered under access to administrative data section. This is not a Meaningful Use issue, but a payer issue and critical. |
| 1. **Claims data at the point of care.** ONC should consider promoting adoption of standards/functionality around the capacity to view and analyze claims data within HIT applications. | **Consider removing:** We probably don’t want to drive claims data into the EHR. Claims are useful, as stated above, but not for clinical decision making at point of care because of the significant timelag associated with them. |

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| 1. **Administrative Simplification.** 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 across the spectrum of patients than any one organization may serve. |  |
| 1. **Reporting simplification.** HHS should hasten its efforts to  standardize all measures required by its various agencies, departments, and programs and create a single central repository where these measures are can be made available to all interested entities. HHS should also continue to support efforts to align these measures with other payers so that all unique and relevant measures are submitted once by a given provider to the central repository where they can be accessed by other payers, thus eliminating the need to report performance measures to multiple payers in multiple formats. | **Scope issue:** This is an important sentiment, but does it extend beyond HITPC’s scope? If the HITPC is looking at policy to improve outcomes, this would be included in its scope. |
| 1. **Administrative procedures.** 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. | \*ADDED RECOMMENDATION\*  CAQC is doing some of this, but slowly and without Federal recognition. Meanwhile, there are a host of payers with a host of different procedures for Prior Auth. Some Medicaid programs still require downloading a form and faxing it in. |
| 1. **Review regulatory burden.** 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 recommendation to CMS regarding which are important for patient care and which represent mostly administrative burden. | \*ADDED RECOMMENDATION\*   1. **Consider removing:** This may be over-reaching, but important to recognize how the burden detracts from value that users experience from EHR use and adds to practices that undermine good care e.g. like “cut and paste.” |
| 1. **Clinical decision support efficacy.** ONC should conduct an evaluation of the efficacy of existing CDS tools and consider approaches to improve same. | \*ADDED RECOMMENDATION\* |