**Draft Accountable Care Workgroup Recommendations Document – February 6, 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.

*Framing Statements:*

* The ACWG is concerned with a wide range of value-based payment models that are currently being implemented through both public and private efforts,, These include: Medicare Shared Savings participants,, value-based purchasing programs, advanced primary care payment initiatives, and global payment arrangements.
* The ACWG is seeking to support a common set of core health IT capabilities that are broadly relevant across these arrangements, while recognizing that accountable care arrangements may vary in their specific health IT needs.
* The ACWG is focused on identifying recommendations which: 1) align with business and clinical imperatives; 2) are unlikely to arise from current market forces; and 3) will likely be effective using available federal levers.

*Recommendations for Consideration:*

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| *Original Text* | *Comments/Major Revisions* |
| 1. **HIT adoption and infrastructure.** The availability of a robust health IT infrastructure is crucial to accountable care arrangements. 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.
 | Add some data from Clif Gaus’ hearing presentation regarding start-up costs: Two and quarter million is a hefty downpayment for the first year for a lot of the smaller groups entering the market. |
| * 1. **Meaningful use measure for accountable care programs.** 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 expand 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 requiring at least 50 percent of participating primary care physicians are attesting for Meaningful Use Stage by in each year of ACO participation.
 | Providers who have attested in 2012 should be able to qualify.Clarify that the MU element should be an ongoing requirement. |
| * 1. **Planning elements in accountable care program applications.** As part of the application process for CMS and CMMI programs around accountable care, CMS should require applicants to describe their plans to establish an IT infrastructure to support clinical integration and care coordination during the program, including a focus on steps they will take to exchange clinical information with behavioral health and long term/post-acute care providers.
 | **Clarify scope:** We should define “clinical integration and care coordination” with greater specificity—should we only refer to specific MU objectives?**Consider removing or revising:** Exchanging clinical information with behavioral health and long term/post-acute care providers may be too far-reaching.This integration is critical to care coordination.The key distinction here is the ask for planning, articulating where these other provider types fit into their broader infrastructure vision.  |
| * 1. **Incentives for non-MU eligible providers in accountable care programs**. CMS should establish provisions within the Medicare Shared Savings program under which ACOs can receive access to additional shared savings program for demonstrating clinical data exchange with LTPAC and behavioral health providers with LTPAC and behavioral health providers. These funds can be used to further support investments in developing care coordination infrastructure with these critical partners.
 | **Consider whether this is feasible:** Is there a reason for calling out LTPAC and BH? I’m not sure we even have integration with non-LTPAC providers?**Consider strengthening:** we should expand beyond LTPAC and BH providers here as well to get at the broader ecosystem beyond these core providers, e.g. other MU ineligible specialties, nurse educators, nutritionists, social and human services agencies, providers, case workers, and care coordinators.Emphasis is to recommend CMS help fill infrastructure funding gaps for beyond MU providers.  |

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| 1. **Access to administrative data.** Providers operating under accountable care arrangements are striving to obtain access to 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.
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| 1. **Strategy for scalable data architecture.** CMS should initiate an effort with the State Innovation Model program (CMMI) in order to understand 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 consider:
	* 1. Current examples where all-payer claims databases, HIEs, Medicare qualified entities, and other data aggregators at a community or state level are acting to serve the needs of providers seeking comprehensive clinical and administrative data to support value based purchasing and quality improvement.
		2. Strategies to maximize the value of these investments to Medicaid and other commercial payers, identify models for scale across different regions, and address key barriers.
		3. Promoting best approaches to uniform methods and standards for integrating claims data across multiple sources that can be disseminated across models.
 | **Alternate Language:** CMS should initiate an effort with the State Innovation Model (CMMI) to support the development of APCDs in all states. Since there is variation in how these are constructed, this effort should include:Funding for a study to identify uniform methods and quality control standards for development of these APCDS and recommend minimum edits that should be applied for consistency in data reliability and data integrity.Requirements that states receiving SIM funding have commitment from both Medicaid and private payers doing business in that state to contribute to the APCD.**Regarding alternate language:** I have real concerns about the viability of APCDs or even whether their data will be available to ACOs (there are severe restrictions in some state such as MN). I don’t think we should limit the recommendations to APCDs. Instead I think we need a range of options to support accountable care access to claims data 1) urging commercial payers to share claims data with their ACO partners 2) facilitating many organizational types as the repository and aggregator (QEs, regional quality data intermediaries, HIEs and APCDs) that can combine claims and clinical data for partners 3) facilitating the availability of data enclaves (such as Optum labs) that combine Medicare and commercial data and that can be used for discovery and research (not direct patient care) |
| 1. **Availability of behavioral health claims data.** CMS and SAMHSA should work to overcome existing barriers to the release of Medicare Behavioral Health Claims to providers participating in accountable care programs.
 | HIGHLY important—behavioral health is critical to control of somatic medical problems in a risk contract. Currently CMS (and other payors) are prohibited from sharing MH/BH information even if the Patient agrees to share information. Creates a significant gap in care when the treating physician is unaware of other factors (MH dx, personality disorders, social factors impacting care, and understanding the GAF score). |
| 1. **Availability of claims data for prospective 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.
 | Agreed. The data could be redacted to protect the identities of patients who have not given approval to share their specific claims information. Having to wait until the CMS MSSP effective date creates obstacles to developing pro-active strategies to deal with the medical spend and compliance issues. The total spends on the claims files do not accurately reflect the true nature of the spend. |

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| 1. **Access to Encounter Data.** Patients assigned to one accountable care provider organization may and do seek a significant amount of care elsewhere--care for which the ACO is financially responsible. In order to better coordinate and direct care, providers need real time information regarding where and when their patients are admitted, discharged, or transferred from other loci of care (emergency departments, hospitals, LTPAC, etc.) While this information is ultimately available from plans or in an APCD, the lag time precludes direct intervention at point of care.
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| 1. **Patient Event Notifications.** ONC should focus on developing 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. Many communities with HIEs have successfully deployed this sort of alerting infrastructure, but 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.
 | This seems the low hanging fruit that already has a strong set of business incentives due to readmission penalties.One of the six HHS innovation fellows is currently assigned to ONC to develop this infrastructure. |
| 1. **Social Determinants of Health.** HHS, through the State Innovation Model (CMMI) 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 care and planning purposes. This effort should consider:
	1. How to drive collaboration between stakeholders including Medicaid, social services agencies, and other sites where SDH data resides; and
	2. 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.
 | **Consider refining:** I am not really sure what this is. Are we talking about sharing patient level attributes (so this is really a data sharing exercise) or are we talking about using social determinants data for research and discovery?**Consider additional recommendation:** We should recommend establishing CMMI pilot projects that are structured in such a way to provide this information. When dealing with different States and jurisdictions, we need a few examples and CMMI seems to have the breadth of reach politically, geographically, and culturally to give the government some valuable information on how to move the needle here. |
| 1. **Eligibility and Benefit Data.** HHS should explore strategies to make information about real-time queries of Medicare eligibility and benefit determinations available to providers participating in accountable care programs 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 also align with the settings and services available within the ACO itself.
 | Agree that access to the adjudication system, rather than waiting for the CCFL claims files would help expedite the timely sharing of information. |

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| 1. **Sharing clinical information across the healthcare neighborhood.** Patients, their families, and providers should expect to have consistent and timely access to standardized health information that can be securely shared between primary care providers, specialists, hospitals, mental health and substance abuse services, LTPAC, home and community-based services, other support and enabling services providers, care and case managers and coordinators, and other authorized individuals and institutions (HHS’ HIE Acceleration Principles). While many providers are helping to realize this vision, a variety of factors continue to hold providers back from making sharing of clinical data. HHS should leverage policy and payment incentives, as well as other programs, to encourage broader data sharing.
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| 1. **Identifying and encouraging exchange with ACO partners.** CMS should ask organizations participating in accountable care programs to identify major trading partners as part of their application and report on where trading partners are not exchanging information. HHS could seek to mitigate challenges with partners that are not engaging in exchange and/or publicly report on identified organizations.
 | **Consider removing or adding additional detail:** Unclear how this would work or whether it is a high impact recommendation.**Consider expanding:** We should expand to all types of social service agencies that receive federal and state funding or supply information to the federal and state agencies. HUD, FQHCs - look -a-likes etc.). |
| 1. **Public measures around exchange.** HHS could include a requirement for ACOs to share clinical data electronically for transitions of care, including those with non-ACO providers, and include a suitable measure for transitions of care as part of inpatient quality reporting and publicly report these results through the Hospital Compare Web site.
 | **Consider strengthening further:** The need for ADT data should be highlighted but this is an area that MU Stage 3 could address. Alternate language: CMS should explore ways that Meaningful Use and the EHR ATCB Certification process can require all EHRs to be able to submit real-time HL-7 ADT data to trading partners and other providers of care for patients. |
| 1. **Hospital survey and certification standards.** CMS should explore ways to use the hospital survey and certification process and guidance to state surveyors related to admissions, discharge, and transfer to clarify the need to send electronic discharge summaries in a timely manner to the treating provider regardless of affiliation with the hospital.
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| 1. **Guidance around behavioral health data.** SAMHSA should consider issuance of additional guidelines to clarify issues around sensitive data regulations to address lack of clarity among providers in the field. SAMHSA, OCR, ONC, and CMS should also work together to review CFR 42 and make recommendations for changes that would support better, integrated care as visualized by the health reform community.
 | Agreed. |

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| 1. **Data Liquidity for Accountable Care.** Organizations responsible for the total cost of care for their patients must be able to manage patients across the continuum of care; providers in accountable care arrangements are seeking to integrate across different systems and among a range of health IT tools 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 the health IT certification framework and other levers to drive interoperability across both EHRs and a support the development of a broader set of HIT tools that must work together within an ecosystem supporting accountable care.
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| 1. **Interoperability standards.** ONC should continue to develop more specificity in federally recognized interoperability standards that are critical to promoting seamless flow of information across systems within the ACO environment, such as discrete HL7 data feeds for admissions, discharges and transfers, notifications, labs, prescriptions, etc.
 | **Consider additional specificity:** We should include such standards as potential requirements for certification to participate in programs such as Meaningful Use stage 3.Highly important—the market won’t do this by itself. |
| 1. **Common API.** The HIT Standards 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.
 | **Clarify jurisdiction:** Is this an HITSC or an HITPC issues? |
| 1. **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:** this may not be appropriate or relevant. If a large integrated delivery system (like Kaiser, the VA, Intermountain Health etc.) has a single vendor they will not need to demonstrate cross vendor exchange, especially if the vendor has a HISP.  |
| 1. **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\*
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| 1. The HIT Standards Committee should direct ONC or another HITSC/HITPC 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. I continue to believe that the goal is to be able 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.
 | Critical aspect. Makes no sense to send what can’t be received. |

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| 1. **Use of data and information at the point of care.** Organizations operating within accountable care models are focused on developing infrastructure that allows clinicians to deliver seamless, coordinated care based around a single view of the patient. HIT applications must support collaboration across the care team informed by point-of-care access to key clinical and administrative data.
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| 1. **Accelerate progress on 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.  |
| 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. |
| 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:** Not sure that this has much value if ACO’s have access to claims data from either APCDs or payers directly. Claims are useful, as stated above, but not for clinical decision making at point of care because of the significant timelag associated with them. ADT data is real time. So is clinical data from EHRs.**Consider removing:** Agree that we probably don’t want to drive the claims data into the EHR. |

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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. This additional burden poses challenges to successful participation by provider organizations and adds costs to the system.
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| 1. **Reporting simplification.** The HIT Policy Committee should support ONC and HHS developing a vision for how to eliminate all redundancies and variations in the quality reporting requirements among HRSA, SAMHSA, and CMS and an associated strategy to build toward this vision. This strategy could seek to define an environment in which every measure is calculated once in a standardized format at the provider setting level or by an intermediary, and then submitted to an intermediary or central HHS warehouse where it can be accessed by the agencies that may require it. Strategy should also extend to commercial payers who could align with and utilize this infrastructure.
 | **Scope issue:** This is an important sentiment, but does it extend beyond HITPC’s scope? |
| 1. **Measure alignment.** HHS/ONC should continue to support efforts to align ACO metrics with other payer, state and federal quality and performance metrics, as well as with HL7’s Consolidated-CDA standards, Meaningful Use, and public and private payer billing requirements.
 | **Consider removing:** This is repetitive with recommendation above. |
| 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 physicans 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\***Consider removing:** This seems over-reaching. |
| 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\* |