Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

Accountable Care Workgroup: Draft Recommendations

April 8, 2014

WORKGROUP BACKGROUND AND INTRODUCTION

Accountable Care Workgroup Members

First workgroup meeting: April 2013

WG Members

- Charles Kennedy, Aetna (Cochair)
- Grace Terrell, Cornerstone Health Care, P.A. (Cochair)
- Shaun Alfreds, HealthInfoNet
- Richard (Hal) Baker, Wellspan
- Karen Bell, JBS International
- Craig Brammer, Healthbridge
- Scott Gottlieb, American Enterprise Institute
- Heather Jelonek, John C. Lincoln Accountable Care Organization
- David Kendrick, MyHealth Access Network
- Joe Kimura, Atrius Health
- Irene Koch, Brooklyn Health Information Exchange
- Eun-Shim Nahm, University of Maryland School of Nursing
- Frank Ross, Cumberland Center for Healthcare Innovation
- Samuel VanNorman, UnitedHealth Group

Ex Officio Members

- Akaki Lekiachvili, CDC
- Hongmai Pham, CMMI
- John Pilotte, CMS
- Westley Clark, SAMSHA

Transition from Volume to Value

Volume	→	Value
Denied claims, un-reimbursed admissions and other penalties as payers manage utilization		**Quality improvement increases performance-based reimbursement**
Encourages additional capacity and unnecessary care		**Improved cost structure and efficiency increases profitability**
Provider revenues contingent on volume of services		**Re-aligned financial incentives create diversified revenue sources through shared savings**
Payers and providers as adversaries		**Aligned incentives to provide appropriate care in the best setting**

Population management is complex

Who is in need of preventive care and wellness counseling?

Who is failing to fill prescriptions?

Who is overusing the ER?

Who is not using a PCP?

Who is unnecessarily driving up costs?

Who is struggling with their diabetes treatment?

Who is overdue for important preventive testing?

Workgroup Rationale

- Important to look at policy through the lens of the unique business and clinical requirements of accountable care models
- HIT infrastructure to support population health management and other accountable care capabilities goes beyond core use of EHRs for patient care
- WG can identify priorities among the set of common health IT capabilities that help providers succeed under a range of different value-based payment arrangements

Formal 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.

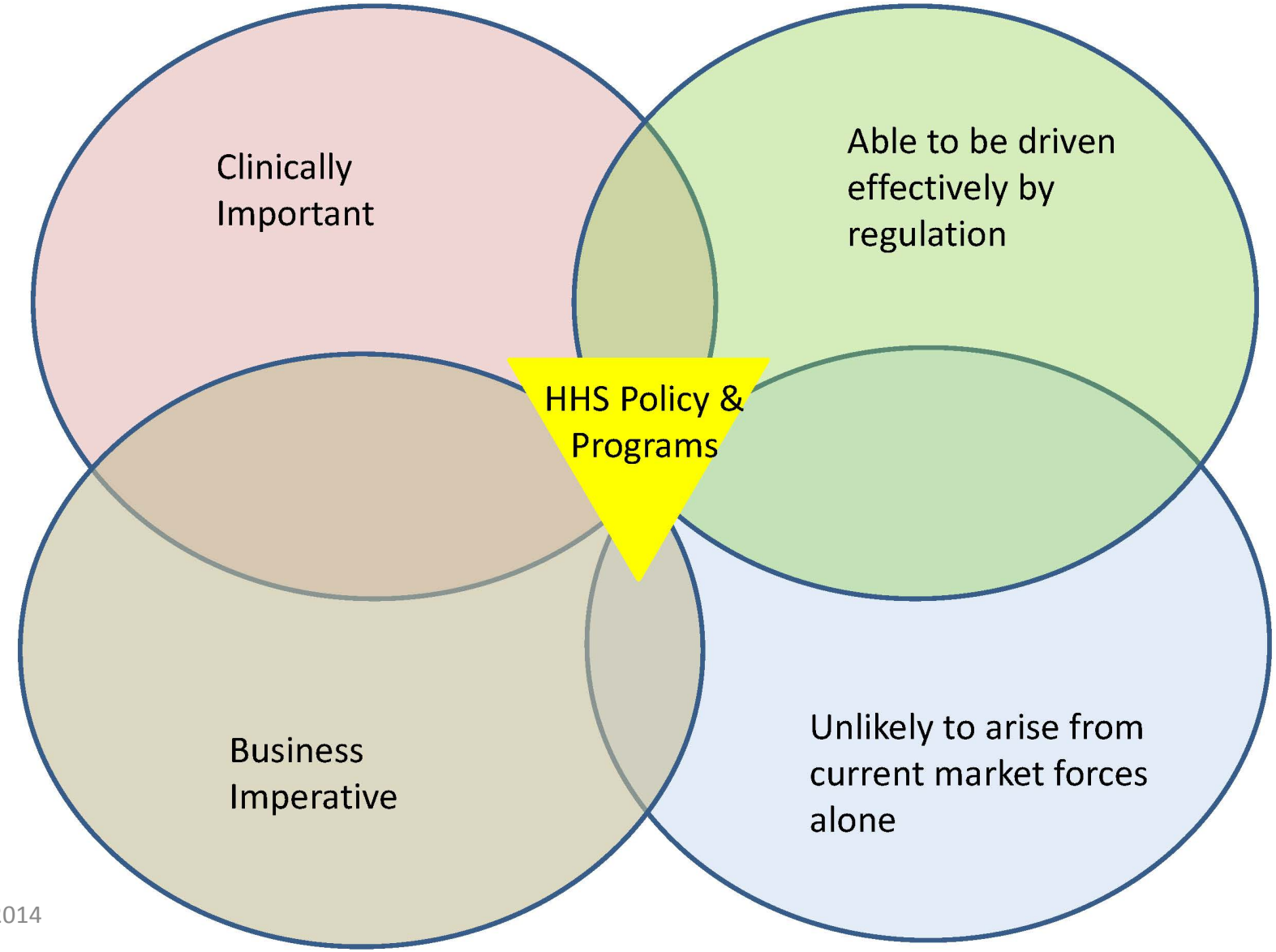
Draft Recommendation Areas

I. HIT adoption and infrastructure.
II. Access to administrative and encounter data.
III. Exchanging Data across the Healthcare Community.
IV. Data Portability for Accountable Care.
V. Clinician use of data and information to improve care.
VI. Streamlining the administration of value-based programs.

Workgroup Activities

- Considered joint CMS-ONC RFI and literature on HIT and accountable care
- Reviewed comprehensive "Health IT Framework for Accountable Care" (CCHIT) in-depth to identify priorities and possible recommendations
- Held public hearing (December 2013) with representatives from different entities participating in accountable care
- Synthesized input and developed consensus around draft recommendations

Criteria for Considering Recommendations



DRAFT RECOMMENDATIONS

I. HIT Adoption and Infrastructure

a. Strengthen requirements around the adoption of HIT for participants in more robust accountable care models (e.g. two-sided risk model under MSSP).

b. Elicit additional detail around HIT infrastructure planning from applicants to accountable care programs.

c. Expand the Advance Payment Model within the MSSP permanent program.

d. Provide additional shared savings incentives to accountable care organizations that include partners who are not eligible for EHR incentives.

II. Access to administrative and encounter data.

a. Encourage the development of state-level all-payer claims databases to support accountable care arrangements (inclusive of Medicare & Medicaid).

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.

c. Make Medicare eligibility and benefit determination data on attributed patients available to accountable care organizations to ensure providers aware of patient health needs.

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.

e. Drive progress on standardization and capture of social determinants of health data elements that are most critical to accountable care delivery models.

III. Exchanging Data across the Healthcare Neighborhood

a. Set expectations that hospitals and health systems participating in federal accountable care models must participate in health information exchange activities.

b. Specify within hospital survey and certification standards that institutions must electronically transfer discharge summaries to treating providers in a timely manner.

c. Increase public transparency around hospitals and health system performance on measures related to health information exchange.

d. Issue additional guidance around sharing of information protected under 42 CFR Part 2 across participants in an accountable care organization.

IV. Data Portability for Accountable Care

a. **Pursue greater specificity in federal interoperability standards around transactional data.**

b. **Strengthen data portability elements in certification criteria.**

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.**

d. **Increase availability of data from remote monitoring devices to engage patients more deeply in their care.**

V. Clinician Use of Data and Information To Improve Care

a. Create a task force to accelerate the development and adoption of standards-based electronic shared care plans across federal programs.

b. Develop pilots to test different shared care plan models.

c. Improve the impact of clinical decision support (CDS) tools by measuring effectiveness.

d. Increase the sensitivity and specificity of CDS algorithm tools by encouraging standards that will support the incorporation of comprehensive data from multiple sources.

VI. Streamlining the Administration of Value-based Programs

a. Align quality measures across all relevant HHS agencies and with private payers.

b. Articulate HHS' future strategy around the infrastructure needed to integrate claims and clinical data to support accountable care.

c. Develop and promote a common standardized methodology and approach to attributing patients in the ACO environment across all payers and providers.

d. Develop standards for administrative procedures to reduce variation in provision of care for ACOs and other providers.

e. Conduct a review of current regulatory burden on providers.

DISCUSSION