HIT Policy Committee
DRAFT
Summary of the November 6, 2013 Virtual Meeting

ATTENDANCE

Members present:

- Christine Bechtel
- Neil Calman
- Arthur Davidson
- Paul Egerman
- Judith Faulkner
- Scott Gottlieb
- Gayle Harrell
- Charles Kennedy
- David Lansky
- Deven McGraw
- Marc Probst
- Troy Seagondollar
- Robert Tagalicod
- Paul Tang

Members absent:

- Madhulika Agarwal
- David Bates
- Patrick Conway
- Thomas Greig
- David Kotz
- Devin Mann
- Aury Nagy
- Joshua Sharfstein
- Alicia Staley

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 53rd meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with an opportunity for public comment and that a transcript will be posted on the ONC website. She called the roll and instructed members to identify themselves for the transcript before speaking. Consolazio introduced three recently appointed members: David Kotz, Dartmouth College, for the privacy and security expert slot; Devin Mann, Boston University, representing researchers; and Troy Seagondollar, United Nurses Association of California, representing labor.

Remarks

Acting Chairperson and National Coordinator Jacob Reider introduced himself. He remarked that in comparison to his predecessor, he is more of a facilitator than a driver. He is looking forward to working with committee members. He kept his remarks very brief in order to contribute to an efficient meeting.

Review of Agenda

Vice Chairperson Paul Tang noted each of the items on the agenda, which was distributed by e-mail prior to the meeting. No additions to the agenda were requested. He asked for a motion to approve the summary of the September meeting. A motion was made by Neil Calman and seconded by Charles Kennedy to approve the meeting summary as circulated with the meeting materials. The motion carried unanimously by voice vote.

> **Action item #1: The summary of the September 2013 HITPC meeting was approved as distributed.**

Data Update from CMS and ONC

Robert Tagalicod, CMS, welcomed the committee to resume its work after the recent federal government shutdown. (Due to the shutdown, the October meeting of the HITPC was cancelled.) He welcomed Jacob Reider. CMS and ONC are committed to working together to implement Stage 2 and plan for Stage 3. CMS will continue to work on privacy and security, both HIPAA and non-HIPAA related. CMS also works with another FACA, NCVHS, on e-health related topics. CMS is committed to consumer engagement via electronic means.

Robert Anthony, CMS, showed slides and presented his standard. As of September 30, nearly $16, 580,000 of incentives had been paid. More than 325,000 unique providers have been paid. Medicaid providers are going from AIU to attestation. Attestation continued during the shutdown. Approximately 83 percent of all eligible hospitals have received an EHR incentive payment for either meaningful use or AIU. Approximately 56 percent of Medicare EPs are meaningful users. Approximately 73 percent of Medicaid EPs have received an EHR incentive payment and 16 percent of Medicaid EPs are meaningful users. Over 60 percent of Medicare and Medicaid EPs have made a financial commitment to an EHR. Over 325,000 Medicare and Medicaid EPs have received an EHR incentive payment. October is typically a slow month for the incentive program, with participation increasing to a peak in January. Over three years, returning EPs have maintained or increased performance on core and menu objectives. Anthony closed saying that he will report at the December meeting on 2014 resources for Stage 1 and Stage 2 and on lessons learned from small and rural EPs. Members had no questions.

Jennifer King, ONC, showed slides and reported on the status of the certification program. Eighty-percent of EHs that attested to Stage 1 used a primary vendor that had any 2014 Edition products. Rates varied by size and location of EH from 75 percent of CAHs to 86 percent of large EHs. Sixty-nine percent of EPs that attested to Stage 1 used a primary vendor that had any 2014 Edition product—55 percent of rural EPs and 56 percent of urban EPs with very little variation by specialty, except for the lower rate among radiologists. Seventy-three percent of hospitals have attested to meaningful use; only 5 percent are not participating. Eighty-three percent of Medicare discharges occurred in hospitals that have attested. 47 percent of EPs have attested. The slides showed the findings of ONC's analysis by primary vendors with one or greater percent of penetration. Leaders were MEDITECH (20 percent), Cerner Corporation (14 percent), Epic Systems Corporation (14 percent), Computer Programs and Systems, Inc. (11 percent) and McKesson (10 percent).

Certification and Adoption Workgroup - Care Planning Hearing Update

Co-chairperson Larry Wolf showed slides and talked about the recent hearing on care planning. After describing the participants and testimonies, he summarized several main points. Senate Bill S.1439 supports patient-centered care planning for serious illness. Several members of the House of Representatives have circulated a letter in support of care planning and HIT standards. Personal statements that clarify intent and anchor emotions are key factors in care planning. The respective roles of a health care representative, agent, and medical power of attorney change over time and must be understood by actors. The advance care plan, advance directive, and physician orders for life-sustaining treatment (POLST) are important documents and have different purposes. State and consumer-controlled registries offer a single place for access and to manage versions of documents. A number of states are at various stages of establishing registries. West Virginia and New York have established POLST registries. MyDirectives is an example of a private registry.

Although the workgroup has not yet formulated recommendations, members have identified the following areas for consideration:

- Think broadly about care planning and individual decisions
- Think beyond the critically ill, and those 65 and older
- Investigate repositories with 24x7 access to the latest version, using live links and static documents
- Learn from what is working now and execute pilots to learn more

Existing repositories, vendor capabilities, provider implementation, EHR processing of advance care planning and POLST, the updated C-CDA to support care planning, and InfoButton constitute resources for learning more.

Discussion

In response to questions from Tang, Wolf said that although state laws on care planning vary, providers are open to considerations of documents in another state. The lack of planning documents is the more serious problem. Regarding the capability of EHRs to communicate with registries, the testimonies did not reach that level of detail. He advocated exploration of what data registries need and use. No opposition to current meaningful use requirements was voiced. Panelists indicated that they wished to do more.

Wolf said that he did not know the answer to Seagondollar's question about the differences among POLST, M(Medical)OLST, and OLST and their relationships to state laws. The release of information is controlled more by the individuals involved than by state requirements. Seagondollar noted the importance of getting ahead of adverse events: Can EHR vendors flag that directives or orders are on file? A suggestion was made to pursue completion of advance planning information into the care plan at the care setting. Then the information could be send to a repository, or the patient could be directed to a registry to input her information.

The order of agenda items was changed due to the temporary absence of a workgroup chairperson.

Privacy and Security Tiger Team - Data Intermediaries Update

Team Co-chair Paul Egerman reported that the tigers are considering the output from the September 30 hearing on accounting for disclosures. They expect to submit draft recommendations at the December HITPC meeting. The hearing topic generated great interest to the extent that the website was not able to accommodate the 200 persons who attempted to register. Regarding data intermediaries, he reminded the members that the HITPC directed the Quality Measures Workgroup to convene a subgroup, the Data Intermediary Tiger Team, to make recommendations on data intermediary roles, including those related to privacy and security, with the aim of having certification criteria to allow data intermediaries to serve as the module for quality reporting functionality. The Privacy and Security Tiger Team was asked to advise

on whether there are privacy and security considerations to be addressed as part of the certification of data intermediaries. Team Chairperson Deven McGraw reviewed the recommendations on third party intermediaries, September 2010. She explained that the team concluded that although the recommendations on data intermediaries are sound, they raise concern about the adequacy of BAAs in limiting BA disclosure and in promoting transparency. Team members considered two vehicles for implementing the previous recommendations on data intermediaries: Stage 3 requirements or the CMS Proposed Rule on Revisions to Payment Policies under Physician Fee Schedule (78 FR 43362; /19/2013).

The tigers concluded that there was not an appropriate policy vehicle to hold BAs accountable for greater transparency to providers around their uses and disclosures of identifiable health information. Regarding a possible attestation requirement, the team concluded that attempting to hold providers accountable for the behavior of data intermediaries was problematic and there was a lack of policy vehicles available to directly regulate these entities. Members noted the potential large number of data intermediary BAs, difficulties in identifying them, and defining exactly what is meant by BAs provisions regarding transparency. Policy can be revisited as the environment continues to evolve.

Nevertheless, the tigers asked to share key points raised during deliberations and offer these to the HITPC for consideration. The discussion highlighted a serious concern that the superior bargaining power of large data intermediary BAs results in providers being "forced" to agree to BAAs and DUAs granting BAs broad rights to future uses and disclosures of provider data. Patients have no say in whether or how data intermediaries use their information; these uses are not transparent to patients. The greater the proliferation of data intermediaries, the greater is the risk that problems will occur. Team members think that it may be desirable to define quality measures in such a way that they can be derived solely from the data already in EHR systems, thus limiting the number of data intermediaries that need to be involved. The team recognizes that other factors may need to be considered and concluded that such a recommendation would be beyond its scope, but offers it to the HITPC for further consideration.

Discussion

Tang noted that patients are unaware of the use of their PHI by intermediaries. What about making BAAs transparent to patients either via providers or by posting on the BA websites? Egerman acknowledged concerns with what BAs do with patients' data. However, the team did not want to impose an additional burden of notifying patients on providers. McGraw reported that any one institution may have hundreds of BAAs, making it impractical that providers attest to transparency. She offered to take Tang's suggestion back to the team, but she warned him of the certainty of push back. She reported that OCR recently announced its intention to increase audits of CEs; perhaps OCR staff could look at BAAs.

David Lansky was concerned about restricting quality measures to EHR data. He presented an example of an intermediary capturing data, which are then used for case finding and drawing a sample of patients for post event or encounter interviews. Providers must consent in order for the intermediary to contact patients and request their consent to interview. The industry needs a policy to handle this use case. Providers can create barriers to quality measurement. A policy solution to monetize similar functions is desirable. Egerman immediately objected to monetizing. McGraw pointed to the inefficiencies inherent in a use case by use case approach.

Calman spoke about finding a balance of privacy and advancement of scientific knowledge. Mobile data are a requirement for quality measurement and research. Although patients are justifiably concerned, it may be impossible to control the flow of data.

Kennedy agreed with Calman, saying that the quality measures data analyzed by intermediaries with large Ns and several databases are much more useful than EHRs data alone. Egerman said that ACOs are like

CEs, although they may not be CEs. Data intermediaries are like vendors. Kennedy observed that ACOs may constitute a small percent of overall business.

Gayle Harrell said that providers should inform patients of the role of intermediaries. Judy Faulkner said that with a paper process patients were not informed of all uses of their data. Tang retorted that electronic data can be widely disseminated.

Kevin Larson, ONC, referred to the CMS Proposed Rule on Revisions to Payment Policies under Physician Fee Schedule, and the reference to BAAs as driving the ONC request for the advice of the HITPC.

Tang acknowledged that he wished to tip the balance toward providers in order to level the playing field per intermediaries. He asked the team to continue to work on the topic. McGraw emphasized that the topic is too time consuming to consider in a global context. However, the team will deal with some aspects of the issue under the topic of accounting for disclosures, which she declared is the team's current assignment. She did agree to inquire and report back on OCR's new authority to regulate BAs. Tang urged her to work on a recommendation.

Seagondollar wondered why an intermediary needs identified data for research. Larsen explained that the use case is quality measurement, not research. Identified data are required to follow specific patients across entities.

Reider Announcement

Reider interrupted with a new agenda item. He announced that the CHPL list has been updated with testing conducted during the shutdown. Newly certified products are listed. Product test results are now being posted, with back loading to be completed by EOM. User centric design results will be posted to help vendors to produce more useful products.

Information Exchange Workgroup - Data Portability Update

Chairperson Micky Tripathi referred to the presentation slides and reviewed the background. At the August HITPC meeting, the workgroup's recommendation on data portability was not accepted. Subsequently, the workgroup members revisited data portability. They solicited presentations from the EHRA and S&I Framework. They found that data migration and patient portability are unique use cases that need to be considered in standards development initiatives. Current standards efforts do not necessarily address these needs. Certification currently includes some migration functionality. EHRA suggested that for data migration the document approach is not sufficient for all intended uses. The C-CDA can satisfy some needs but other methods are required to move all relevant data. The C-CDA is a good fit for the patient portability use case. In general, complex data migrations do not lend themselves to the uniformity imposed by product certification. The workgroup focused on two use cases: provider data migration when the provider switches from one or more EHR systems to another and patient portability when a patient requests the movement of her complete record (e.g. to a new PCP). Since significant work will be required for seamless movement of data and because of the important role that migration plays in care, the workgroup recommended a multiple step path, first setting a floor.

Tripathi paused to consider questions. Egerman noted that people challenges are greater than the technical challenges. Workgroup Co-chairperson McGraw presented the following recommendations:

> The HITPC recommends that the HITSC, by Stage 3 of Meaningful Use, develop standards and technical specifications to address both the provider data migration and patient portability use cases (to include such cases as patient care, clinical quality metrics and clinical decision support).

- The HITSC should determine the necessary elements of a core clinical record that will establish a first step on the path towards improved data portability for patients and providers.
- The HITPC suggests the HITSC explore the adoption of a core clinical record that is easily extractable and consumable by EHRs to support the provider data migration and patient portability use cases.

ONC should establish a long term path to move the industry towards a practical patient portability and provider data migration solution that addresses the key policy concerns identified by the HITPC. ONC should:

- Investigate the current state of the field and create a needs assessment to lay the path for future standards work to reach this vision.
- Explore policy levers in addition to certification that could help facilitate patient portability and provider data migration portability (i.e. ACO continuity of record requirements, legal medical record requirements, etc.).

Discussion

Egerman emphasized his opposition to the recommendations, saying that standards would not be available. Tripathi assured him that the workgroup had tried to take his comments into account. The 2014 Edition contains requirements for a common data set. The recommendations extend the requirements to these two use cases. Egerman continued to argue saying that those requirements are for other purposes. Faulkner also was opposed, saying that vendors did not map their data elements. She used sex (actually gender) as an example; some vendors use female and male only while other vendors have additional categories. McGraw attempted to locate an area of agreement. If these use cases are important to address and Stage 3 is unrealistic, perhaps looking beyond Stage 3 is the answer. She observed that most people agree that portability and migration are important for exchange, but are not being addressed. Faulkner talked about conversion being done vendor to vendor, which, according to McGraw, does not work for patients. Egerman continued to argue that the best way to proceed is by looking at specific documents. Migration and portability are not information exchange. Scarce resources are better used for quality improvement or information exchange. Christine Bechtel disagreed with Egerman. Recognizing that switching vendors is not uncommon and is expected to increase, she pointed out that consumers need to be assured that their data will be preserved across changes in EHRs. The core data set should be mobile. She wondered what is in the core set. Tripathi said that he did not want to get into that level of detail. The 2014 Edition does not include longitudinal data. Bechtel referred to Blue Button and VDT: Is it important to have a standard to ingest these data? Tripathi said that although ingestion is important, not all systems are configured to generate CDAs for the entire patient history. Faulkner observed that it is not technically reasonable to expect to migrate all data in actionable form. Tripathi agreed, but said that some components most essential for action could be identified. There are 16 elements in the 2014 Edition core set. He suggested asking the HITSC about the sufficiency of the core set.

Lansky argued for retaining the Stage 3 timeline. He suggested an intermediate step—a feasibility study per Stage 3 to include options. McGraw suggested asking the HITSC for a realistic approach and timeline.

Terry Cullen described matching problems in her organization. She referred to semantic interoperability and process interoperability. Although there is a need to push, the work will be slow and labor intensive. There is no point to push something that people cannot do. McGraw asked for language for a revised recommendation. Cullen said to focus on one use case for piloting and to examine which elements in the data set can be transported and which can be consumed.

Tang called for closure. McGraw moved to accept the first recommendation modified to seeking advice on approach and timing, rather than specifically calling out Stage 3. Bechtel seconded the motion. The motion was unanimously approved by voice vote.

> **Action item #2: By voice vote, the members unanimously approved a motion to accept the recommendation that the HITSC be asked to advise on timing of, and develop standards and technical specifications to address both the provider data migration and patient portability use cases (to include such cases as patient care, clinical quality metrics and clinical decision support). The HITSC should determine the necessary elements of a core clinical record that will establish a first step on the path towards improved data portability for patients and providers. The HITPC suggests the HITSC explore the adoption of a core clinical record that is easily extractable and consumable by EHRs to support the provider data migration and patient portability use cases.**

Quality Measure Workgroup - Meaningful Use Stage 3 Deeming Update

Accountable Care Subgroup Co-chairperson Terry Cullen explained that the Accountable Care Subgroup was formed to develop recommendations for the next generation of e-measure constructs that are patient and population centered, longitudinal, cross settings of care where appropriate, and address efficiency of care delivery. Its focus was to be on the domains, concepts, and infrastructure that can be applied to populations (e.g., Accountable Care Organizations (ACOs). But the subgroup was instructed to first consider deeming. Members agreed on a framework in which health (not health care) is the primary outcome and is populations based. They deliberated on the criteria for deeming and considered which measures that currently exist in CMS programs are appropriate for deeming. They also considered what parameters could be used for a group reporting option for meaningful use overall (including deeming). They accepted these assumptions:

- Criteria are for measure sets, not for individual measures
- The criteria are intended to be applicable for individual EP or EH reporting and population or group reporting
- Reporting may be through "self-defined" groups

Workgroup Chairperson Helen Burstin presented recommendations on the following criteria for selection of deeming measures for application across EPs, EHs, and populations:

- Prefers eCQMs or measures that leverage data from HIT systems (e.g., clinical decision support)
- Enables patient-focused view of longitudinal care; enables assessment of care over time from the patient's perspective across EPs or EHs and across groups of providers with non-eligible providers (e.g. behavioral health)
- Supports health risk status assessment and outcomes; supports assessment of patient health risks that can be used for risk adjusting other measures and assessing change in outcomes to drive improvement

And for population or group reporting, she recommended:

- Preference for reporting once across programs that aggregate data reporting (e.g., PCMH, MSSP, HRRP, CAHPS)
- Applicable to populations: broadest possible experience of the patient/population is reflected in measurement (e.g. require interoperable systems)
- Benefits of measuring and improving population health outweighs the burden of organizational data collection and implementation
- Promotion of shared responsibility, and requires collaboration and/or interoperability across settings

Several exemplars were considered—frail elderly, Million Hearts targets, persons under 65 with disabilities, and primary care patients with mental health diagnoses.

The Quality Measures Workgroup proposes to work on these topics:

- EH/EP measuring together for mutual benefit
- Group reporting option
- Population health aligned with new business models
- Interoperability that matters
- Measures that depend on data from outside the current provider or organization
- Measurement coordination with non-eligible providers (e.g. behavioral health, long term care)
- Infrastructure and architecture for ACO measurement

The ACO Subgroup proposes to work on the following:

- Recommendations on the development of specific measures
- Use of hybrid data sources, e.g., claims and clinical
- Recommendations for group and population reporting for ACO CQMs
- Reporting cycle for ACOs
- Infrastructure for ACO and group measurement

Discussion

Tang directed attention to the color-coded matrix slides. The matrix constitutes the measure set. The green cells indicate appropriate for deeming. Cullen said that some measures are so important that they should not be eligible for deeming.

Lansky declared that he was concerned about the policy aspects of deeming. Tang explained that deeming would require more than reporting on measures. The provider must be a high performer or show strong improvement. Lansky pointed out the lack of historical data and the instability of measures based on small Ns. He said that HIT measurement must be encouraged.

Faulkner expressed serious reservations about the entire deeming concept. Organizations that are not using HIT should not receive incentive payments. For providers, measures will vary across time. It will be difficult to know the boundary for the top quartile. Vendors will have to do two systems—one for deeming and one for standard reporting. Tang informed her that the workgroup was charged to consider measures for deeming, not deeming per se. Deeming would not require double work for vendors since the same measures would be used for deeming and standard reporting.

Egerman said that the process does not exactly fit with deeming. Providers may be able to deem simply by participating in a group. Identification of measures may belong under certification and meaningful use. Burstin repeated that to participate in deeming, a provider would have to be a high performer in Stages 1 and 2. Egerman talked about a collective analysis among a large number of participants. Deeming should be based on effective use of EHRs, not just dumping data into a group database.

Tang referred to assumptions. Nothing will be deemed that was not tested in an earlier stage. Deeming will contribute to the transition to the development and use of tools by providers to manage populations in an ACO-like world. Instead of focusing on certification and checking the use of individual functions, deeming will be based on testing for outcomes. Deeming would be optional. It is assumed that a provider cannot be a high performer or improver without the use of electronic tools. HIT sensitive is an attribute of a measure. Calman pointed to a problem with the exemplars, saying that it appears that performance could be done without HIT. Burstin assured him that the matrix will be corrected to clarify that point.

Faulkner said that deeming seems to imply that Stage 3 will not have new and valuable things. Tang explained that deeming would only apply to a subset of measures. Deemers would continue to report on other measures, some of which may be new to Stage 3.

Bechtel asked about next steps: Will measure sets based on exemplars be recommended? Cullen acknowledged that much work remains to be done. Someone requested more attention to the overall goal of eliminating disparities.

Tang requested additional exemplars. Larsen said that the workgroup members had questions about which objective criteria this particular set would potentially replace. Is that in scope for the Quality Measures Workgroup? Tang declared that the Meaningful Use Workgroup would handle that aspect. However, after two members of the Meaningful Use Workgroup disagreed, he agreed that the Quality Measures Workgroup could work on that problem provided members are willing. Bechtel pointed out that it is difficult for a group to come up with great measures without first identifying the functions. She said that she preferred to have measure sets and the functions that would be deemed.

Cullen talked about the importance of interoperability. Egerman said that measures should be based on the right thing for patients. Cullen noted that ACOs are concerned about the right measures to track patients. Cullen and Burstin indicated that they had received sufficient input from the committee to continue their assignment.

Public Comment

None

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the September 2013 HITPC meeting was approved as distributed.

Action item #2: By voice vote, the members unanimously approved a motion to accept the recommendation that the HITSC be asked to advise on timing of, and develop standards and technical specifications to address both the provider data migration and patient portability use cases (to include such cases as patient care, clinical quality metrics and clinical decision support). The HITSC should determine the necessary elements of a core clinical record that will establish a first step on the path towards improved data portability for patients and providers. The HITPC suggests the HITSC explore the adoption of a core clinical record that is easily extractable and consumable by EHRs to support the provider data migration and patient portability use cases.

Meeting Materials

- Agenda
- Summary of September 2013 meeting
- Presentations and reports slides