

Information Exchange Workgroup's Recommendations on the HIE Request for Information

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Information Exchange Workgroup

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Summary

- HIE is advancing rapidly, however, it is being held back by demand- and supply-side **friction** created by variation in Federal and State programs and policies that give unequal and sometimes conflicting emphasis to interoperability
- An HHS-wide review of the main areas of such friction, and the most effective **combination of levers** for eliminating it, would do much to advance HIE adoption across the country

HIE RFI Response Framework

- With limited time to develop recommendation the Workgroup decided to narrow their focus to **four topic areas** ripe for federal action to advance HIE
 - Payment Policy
 - Providers Ineligible for Meaningful Use
 - State-level program/policy variation
 - Leveraging HHS infrastructure
- As the Workgroup developed recommendations in the various topic areas we considered the following **levers**:
 - Regulation
 - Payment
 - Certification
 - State action
 - Reporting and public reporting
 - Convening authority

Payment Policy

Background

- The **diffusion of advanced payment models** has successfully spurred provider demand for information exchange through a combination of “carrots” (e.g., gain-sharing) and “sticks” (e.g., hospital readmission penalties)
- These models are still **nascent**, however, and there a number of areas where they could be improved:
 - Complexity of requirements
 - Lack of alignment across payor programs, both across public programs as well as across public and private
 - Relatively slow diffusion of advanced payment models and “long tail” of fee-service model

Payment Policy

Recommendations

1. HHS should work to **simplify and harmonize requirements** across advanced payment models for public and private payors. This will help providers focus on the desired outcomes rather than the often complex mechanics of the current programs
2. Since there is still a lag in adoption of HIE capabilities through advanced payment models:
 - Highly focused **supplemental payments** to capitated and fee-for-service models to motivate HIE-enabled activities (e.g., higher E&M coding for “cognitive activities” using HIE, such as information reconciliation)
3. **Voluntary certification** program for HIE functions that enhance enablement of value-based purchasing activities

Providers Ineligible for Meaningful Use

Background

- While MU Stages 2 and 3 are expected to create significant incentives for broader and deeper HIE adoption, **significant sectors of the care continuum do not qualify for financial incentives**, nor are they subject to the corresponding regulatory authority
 - Long-term and post-acute care providers (LTPAC), includes skilled nursing, home health, rehabilitative, custodial, etc
 - Pharmacists
 - Commercial laboratories
- The inapplicability of MU to these types of providers leaves gaps in the HIE incentive and regulatory framework that result in **structural impediments to progress in interoperability** across the care continuum

Providers Ineligible for Meaningful Use Recommendations

1. HHS should **harmonize required documentation** and reporting across programs and with the MU framework
 - Harmonization of CMS-required documentation with CCDA
 - Incentives to Part D providers to motivate HIE-enabled and HIE-enabling activities
 - Advance administrative simplification where it intersects with clinical standardization, such as prior authorization documentation requirements
2. Laboratories
 - Provide **safe harbor from certain CLIA requirements** if providers are compliant with MU and using certified technology
 - Increase **aggressiveness of Stage 3** eligible hospital laboratory results delivery requirements to move the market faster
3. Require (if possible) or facilitate (if not) **voluntary certification** of technology used by providers ineligible for meaningful use, in alignment with MU requirements

State-level program/policy variation

Background

- State-level variation in program requirements and policies impedes HIE adoption by making it **more difficult** for multi-state care organizations and technology vendors to create scaleable processes, services, and products
- Some of this variation lies in **differences in programs** that have Federal and State components (e.g., Medicaid reimbursement, Medicaid waivers, public health, etc)
- Other types of variation lie in differences that are solely rooted in areas where States have **independent policy authority** (e.g., privacy, liability, etc)

State-level program/policy variation

Recommendations

1. CMS should **include HIE requirements in all programs** including state waivers and future advanced payment demonstrations, and require coordination as much as possible with the State HIT Coordinators
2. CDC should continue and increase its work to harmonize the variability across states in the standards utilized for **public health reporting** to enhance use of HIE
3. HHS should create **model language** available for inclusion in state-level programs (e.g., Medicaid MCO contracts, state employee health plans, etc) to encourage HIE activities
4. HHS should identify and encourage any opportunities for reducing state-level variation in **privacy and liability** policies related to HIE activities

Infrastructure

Background

- HHS maintains a **large infrastructure** to manage its various programs related to health care payment, health care delivery, public health, and product regulation
- Some of these infrastructure components and associated services can be **opened up for public use** to catalyze and enhance development of market-based HIE products and services

Infrastructure

Recommendations

1. CMS should repurpose **existing data and business infrastructure** to facilitate market development of HIE capabilities
 1. Apply open data principles to **provider databases** (NPES, MU, NPI) to make data available to market for provider directory creation
 2. Build on **credentialing of patients and providers** to support validation needs for HIE activities (e.g., provisioning patients with Direct addresses)
 3. Enable **patient access to immunization** information contained in public health immunization registries
2. Alignment of **FDA** programs with MU framework, such as device interoperability (facility and home), structured product labeling standards, and event reporting standards

Appendix

Payment Policy

Detailed Recommendations

1. HHS should work to **simplify and harmonize requirements** across advanced payment models for public and private payors. This will help providers focus on the desired outcomes rather than the often complex mechanics of the current programs
 - Harmonize quality and outcome measures across HHS programs
 - Allow deeming of process measures that are nested within corresponding outcomes measures and goals
 - Convene with private payors to align outcomes measures and the use of electronic clinical quality measures (eCQMs)
2. Since there is still a lag in adoption of HIE capabilities through advanced payment models:
 - For those already in advanced payment model, **highly focused supplements to capitated payments** for desired process enhancements, such as more use of HIE-enabled care coordination
 - For those still in fee-for-service payment model, **highly focused payments to support HIE-enabled “cognitive activities”** (e.g., allow higher E&M codes for completion of HIE-enabled medication, allergy, care plan or problem list reconciliation prior to and after a transition-of-care)

Payment Policy

Detailed Recommendations (continued)

3. HHS should consider opportunities for certifying technology to facilitate value-based purchasing activities that go **beyond the MU foundation**
 - **Depth**: deeper integration into EHR workflows; tighter content/vocabulary requirements; more robust reconciliation capabilities such med/problem/allergy reconciliation, etc; eCQM and eCDS
 - **Breadth**: interoperability with broader set of health care settings (e.g., LTPAC, etc); inclusion of broader set of functions (eg, population care management and aligned CDS), measures/CDS (e.g., ACO-specific measurement and reporting capabilities), and data management and analytic capabilities (e.g., claims, risk stratification); ability to consume externally generated alerts

Providers Ineligible for Meaningful Use

Detailed Recommendations

1. HHS should harmonize required documentation and reporting both across programs and with the MU framework
 - ONC should **harmonize the care plan requirements** so that meaningful use eligible providers are able to receive care plans from non-meaningful use eligible providers (e.g., nursing facilities)
 - The clinical elements of **CMS-required documentation should be harmonized** to the CCDA: Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS) and Care Tool, Home Health Plan of Care (CMS 485) and IRF-PAI (Part A fee-for-service rehabilitative inpatient)
 - HHS should **align the MTM and Stars Programs** to incent the sending and receiving of a meaningful use harmonized CCDA
 - CMS should **accelerate levers in Part D** to support cognitive activities such as medication therapy management by pharmacists
 - HHS should continue its efforts to **advance administrative simplification** that would leverage HIE enablement, such as harmonization of prior authorization data requirements with CCDA structured data requirements

Providers Ineligible for Meaningful Use

Detailed Recommendations (continued)

2. Specifically related to **laboratories**
 - A **safe harbor to CLIA's visual verification requirements** should be established for commercial labs if they utilize the meaningful use standards for transmitting labs to an EHR that is meaningful use certified
 - In Stage 3 of meaningful use CMS should make the **eligible hospital objective** to provide structured electronic lab results to ambulatory providers a core measure and increase the required measure as aggressively as possible
3. ONC should encourage **voluntary certification programs** to support Meaningful Use ineligible provider participation in health information exchange, either formally (if statute allows) or in collaboration with private certification entities
 - Standardize certification of **Home Health providers** across the country and harmonize documentation requirements with the CCDA
 - Certify technology to **support CCDA-harmonized documentation** (e.g., MDS for nursing facilities, OASIS and Home Health Plan of Care for home health, IRF-PAI for inpatient rehabilitative facilities)
 - Certify **EP EHR technology to receive** relevant CCDA-harmonized structured documents from MU ineligible (eg. Home Health Plan of Care from home health providers)
 - Authorize relevant MU ineligible for **other HHS electronic documentation programs**, such as esMD

State-level program/policy variation

Detailed Recommendations

1. When CMS approves **state waivers** for advanced payment models, where applicable, they should require the alignment of the outcomes and process measures with those established in Medicare advanced payment programs
2. CDC should continue and increase its work to harmonize the variability across states in the standards utilized for **public health reporting** to enhance use of HIE
3. CMS should continue to include HIE requirements in **future advanced payment models, programs and solicitations**
4. Where appropriate, HHS should require coordination with the **State HIT Coordinator** when releasing state level programs and solicitations, and also require ongoing coordination during implementation of these programs/solicitations and strongly encourage such coordination in all other relevant areas

State-level program/policy variation

Detailed Recommendations (continued)

5. HHS should establish a **framework for HIE maturity** similar to the MITA framework. This framework can provide a roadmap to ACOs, health care providers, exchange entities, States and others that have to enable HIE to support their work.
 - e.g., States submitting an IAPD for 90/10 funding are currently required to describe how their HIE activities will mature over time
6. HHS should work with states to implement **common language** across state employee health plans, Medicaid (including Medicaid managed care organizations) etc, that will help advance HIE.
 - For example states could require in solicitations for MCOs and/or the state employee health plan that applicants require participating providers to electronically exchange health information at care transitions
7. On **privacy policy variation**, HHS should review the recommendations developed by the Health Information Security and Privacy Collaboration (HISPC) to determine if there are items that could be productively advanced today
8. HHS should review whether **variations in liability** related to HIE activities is a current or possible future barrier to adoption

Infrastructure

Detailed Recommendations

1. CMS should continue their open data efforts by publishing **NPI, MU attestation, NPPES** data to support the establishment of provider directories.
2. HHS should explore opportunities available through their **existing credentialing infrastructure** for organizations and individuals to see if this infrastructure could be leveraged to support validation/authentication needs for HIE.
 - e.g., Leverage/repurpose the validation that occurs for a patient to access their Medicare claims information to issue and manage Direct addresses
3. CDC should work with states to enable patients to **access to their immunization information**, as a number of states do today. CDC and ONC should work together to develop a roadmap of methods that states can utilize to give patient access to immunization information either through patient-controlled applications and/or through provider-tethered applications
4. FDA should require or encourage **device interoperability** to make it easier for information to be extracted from medical devices, including home monitoring devices (e.g., home blood pressure monitor) for both providers and patients.
5. FDA should **align its structured product labeling standard** with those adopted by ONC and NLM. FDA should harmonize with NDC with RxNorm.
6. FDA should **harmonize its event reporting standards** with SNOMED