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Accountable Care Organizations as Drivers for Trusted and Valued Information Sharing

Response to the Centers for Medicare & Medicaid Services' Request for Comments on the Medicare Shared Savings Program: Accountable Care Organizations Proposed Rule¹

This comment represents a collective view informed by the many and diverse collaborators of Markle Connecting for Health.

I. Introduction

Markle Connecting for Health, a public-private collaborative of more than 100 organizations across the spectrum of health care and information technology (IT), appreciates the opportunity to comment on Accountable Care Organizations (ACOs) within the Medicare Shared Savings Program.

The basic concept of an Accountable Care Organization represents a needed shift in priorities for transforming the health sector toward more continuous and cost-effective care. The proposed rule sets three broad and ambitious aims of better care for individuals, better health for populations, and lower growth in expenditures.

In this letter, we build upon our past collaborative comments on how the Department of Health and Human Services (HHS) can foster the trusted information sharing necessary for ACOs to succeed. We focus only on key ingredients for the health information sharing and information technology components of ACOs.

A 'Culture of Quality Improvement'

Although there is much uncertainty about how ACOs will be developed and implemented, it is clear that they will be required to share information at much higher levels than is the current practice today. By focusing on achieving quality and safety goals, the Medicare Shared Savings Program creates an incentive to

¹ Centers for Medicare & Medicaid Services; Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations and Medicare Program; Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice. 76 Federal Register 67 (7 April 2011), pp. 19528-19654.

share information to support better decision-making and more effective care processes that improve health outcomes and reduce cost growth.

We encourage the Centers for Medicare & Medicaid Services (CMS) to think holistically about the necessary ingredients for providers and patients alike to trust this new information sharing so that ACOs can make significant and measurable progress.

Aligning payment with quality and efficiency goals through the Medicare Shared Savings Program is a critical step in moving toward a high-performing health care system. But to achieve these goals, the health care system must embrace and be an active part of creating the kind of change that will be necessary to operate in an environment that supports information-rich health care.

More important than any program specifications or granular reporting requirements, CMS must communicate a broad vision for a “culture of quality improvement” supported by an ecosystem of information-rich health care. The culture must engage both patients and health care professionals actively in quality improvement. It must reinforce a commitment to excellence and lifelong learning. In this vision, providers and patients understand the circumstances under which information is shared, and trust that risks will be minimized through transparent policies and practices.

For this ecosystem to work, information sharing must be embedded in systems of care designed specifically to improve decisions for patients, their families, and the health care system, always evolving around the needs of patients and reducing administrative burdens. Information gathering and reporting activities should be seamlessly integrated into the provision of care, generate results and benchmarks, meaningfully combine various sources of information, and be available to providers and patients to refine and improve systems of care. Information should support coordinated and appropriate care. This approach must be accomplished without placing onerous time and administrative burdens on providers and their staffs.

The Medicare Shared Savings Program can help accelerate culture and transformations by aligning with and reinforcing other quality improvement efforts such as the Meaningful Use Program and National Quality Strategy.

The vision of information-rich health care guides our recommendations below.

II. Recommendations

These comments are limited to the health IT and information sharing aspects of the proposed rule. Clearly, many legitimate questions and concerns about ACOs fall outside this limited area. Regardless of how these other issues are addressed and resolved, information sharing will be a core requirement for achieving the goals of the program. In that regard, we comment on four distinct categories:

- A. Improve decision making throughout the care continuum by leveraging the insights gained from the data received from ACOs.
- B. Align with and build from the investments in Meaningful Use.
- C. Adopt and implement a complete trust framework based on Fair Information Practices (FIPs) that is consistent with the shared set of policy and technology principles developed by the Federal Health IT Task Force.
- D. Engage patients through improved access to their own health information.

A. Improve decision making throughout the care continuum by leveraging the insights gained from the data received from ACOs.

ISSUE: To create a “culture of quality improvement,” CMS has a critical opportunity to set clearly defined goals and priorities. Information that can improve care and redesign systems of care must be available to the patients and clinicians in the best position to use it to improve quality. The process to demonstrate performance and savings can build capacity for quality improvement, lower administrative burdens on providers and patients, and, if done strategically, support national quality improvement goals.

RECOMMENDATIONS:

1. In keeping with the objectives of Open Government, publish aggregate summary and benchmarking information on quality and patient experience based on data received from ACOs in places that are open to the public, such as [HEALTH.DATA.GOV](https://www.health.data.gov).
2. Give providers access to the aggregate quality and cost information they need to improve care when and how they need it.
3. Enable reporting through certified health IT to help minimize unnecessary burden and cost.
4. Enable data collection as a byproduct of using certified health IT within routine clinical workflows. Providers should be able to calculate measures and submit their results without significant additional overhead and effort.
5. Adopt “measures that matter” —measures that are proven and demonstrate improved health outcomes and greater cost-effectiveness.
6. Support education and outreach efforts to assist ACOs with quality improvement and to foster a learning community of practice.

RATIONALE: Quality and efficiency standards have the potential to serve a meaningful role for both ACOs and CMS in the Medicare Shared Savings Program. They not only serve as the basis for payment, but can be used as key pieces of the quality improvement process. Therefore, CMS must carefully consider how it collects and distributes quality and cost data so that the collected information can be summarized to add value for program participants.

Importantly, the reporting process should leverage existing tools such as certified health IT and registries to minimize redundancy. ACOs would have a greater incentive to adopt certified health IT, for example, if they could report their performance simply as a byproduct of using these systems to deliver care.

CMS will be in a position to provide valuable information that ACOs can use to improve care. In addition to providing individually identifiable claims data back to ACOs, CMS could provide access to comparative benchmarking data derived from claims and reported quality and patient experience measures. Benchmarking information and comparative norms can be enormously valuable to ACOs to gauge their performance, understand what is achievable, and to change systems of care that will improve their results.

In fact, CMS could play a foundational role for quality improvement initiatives across the country by offering the public access to summary national, state, and local benchmarks of health care performance through HEALTH.DATA.GOV based on the information they receive and share with ACOs. This information could be used to spur innovation across the country, just as we have seen with the Health Indicators Warehouse. Many public and private sectors developers use data from the Health Indicators Warehouse to create applications that make use of the data to improve decision-making. For example, BlueMeter² combines data from diverse information sources, such as blue button downloads from CMS and the VA, and the Health Indicators Warehouse to provide consumers with visualizations of their health information and how it compares to peer benchmarks as a way to encourage active engagement in self-health management. If developers could access benchmarks of robust quality measures, they could incorporate them into tools such as the open source popHealth³ tool developed by the Office of the National Coordinator for Health Information (ONC), which gives providers a dynamic dashboard with their quality measures. This dashboard could gain value if it also displayed relevant benchmarks to help providers prioritize quality improvement activity and identify places where they may be lagging relative to their peers.

In addition, ACO networks provide fertile ground for rapid advancement in research, particularly in the clinical problems facing practitioners every day. CMS should explore how to engage ACOs in testing networks to continually evaluate what works and what does not, and to spread best practices.

² See <http://www.data.gov/communities/node/81/blogs/4876>.

³ See <http://projectpophealth.org/>.

B. Align with and build from the investments in Meaningful Use.

ISSUE: Strategically aligning ACO quality goals, as well as the technical and policy requirements of Meaningful Use, will create clarity, leverage existing progress, and enable consistent implementation of health IT and information-sharing efforts across the country. Too many different measures, requirements, and disparate objectives can have the effect of diluting the objectives, obfuscating the true quality improvement goals, and miss leveraging the incentives created by other programs.

RECOMMENDATIONS:

1. Strategically align the Meaningful Use and Shared Savings Programs to maximize investments in both.
2. Establish a mechanism to accept ACO quality reports directly from certified health IT.
3. Continue to align health and efficiency objectives across the Meaningful Use Program and Medicare Shared Savings Program.

RATIONALE: In an effort to maximize the investments of the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Affordable Care Act, HHS should align the programs where possible. To the extent that the requirements for these programs are aligned, it can ease implementation, create necessary focus for participants, and sustain innovative efforts designed to achieve these important goals.

When used as a foundation for other initiatives, the Meaningful Use Program can be amplified and establish the basis of a national infrastructure for information sharing.

Establishing requirements that a percentage of ACO primary care physicians must meet HITECH Meaningful Use requirements is an important first step. While we are not in a position to comment on specific threshold levels for other providers, we believe more thought should be given on how to incentivize them to participate in Meaningful Use in order to leverage potential synergy between the two programs.

However, it is also important to allow ACOs flexibility in how they choose to implement health IT to improve quality and efficiency. Overly prescriptive requirements could unnecessarily stifle innovation. The proposed rule strikes a good balance in encouraging the use of health IT, while not prescribing specific applications or functions, and allowing ACOs to determine how best to use and evolve health IT for quality improvement.

C. Adopt and implement a complete trust framework based on Fair Information Practices that is consistent with the shared set of policy and technology principles developed by the Federal Health IT Task Force.

ISSUE: Policies to protect the privacy and security of an individual's health information are prerequisites for robust information sharing. Consumers and clinicians must trust that personal data will be protected if they are to support information sharing in ways that improve the health and care of individuals and populations, and support greater efficiency.

RECOMMENDATIONS:

1. Support trusted information sharing through the adoption of a comprehensive trust framework. A starting place is the policy and technology framework described in a 2010 memorandum from Vivek Kundra, the White House Chief Information Officer, and Dr. David Blumenthal, the former National Coordinator for Health Information Technology, that was issued to coordinate health IT across HHS and other federal agencies.⁴ The memorandum suggests that each agency use a full complement of policy and technology principles in defining the specific policies, practices, and technology choices that will need to be a part of any health information sharing effort.
2. Support patient trust through policies that apply the FIPs-based principles of transparency and participation.
3. Develop plans to study the extent to which patients would prefer to opt out of having their claims information shared with ACOs, and the conditions under which patients will agree to allow this information sharing. Analysis should examine the implications for ACOs if a patient opts out of this information sharing, including the extent to which it would affect the patient's care or impede the ACO's ability to provide care that achieves quality and cost objectives. These studies should be conducted in an open and transparent manner.

RATIONALE: The Markle Survey on Health in a Networked Life found that more than 80 percent of both the public and doctors surveyed considered privacy safeguards to be important requirements for similar federal investments in health IT. Both groups expressed the importance of specific privacy policies, including breach notification, audit trails, informed choices, and the ability to request corrections. As in past surveys, public support for these privacy-protective practices has consistently remained very high.⁵

⁴ The Health IT Task Force is a joint initiative of the Office of Management and Budget and ONC. A federal Memorandum calls for select federal agencies to coordinate Health IT investments around a shared set of policy and technology principles to maximize the benefits health IT has to offer providers and patients. More information is available at <http://www.cio.gov/Documents/Health-Information-Technology-Guidance.pdf>.

⁵ Markle Foundation. *The Public and Doctors Overwhelmingly Agree on Health IT Priorities to Improve Patient Care*. January 31, 2011. Accessed on the Web May 25, 2011: <http://www.markle.org/publications/1461-public-and-doctors-overwhelmingly-agree-health-it-priorities-improve-patient-care>.

Several federal agencies have a key role to play in health information privacy policy development and enforcement. It is critical that agencies and departments throughout the federal government coordinate their roles and responsibilities so that, whenever possible, consistent requirements can be applied to offer meaningful protections to consumers, and to avoid unnecessary confusion in the marketplace.

In our experience, the specific privacy policies and practices articulated in the Markle Common Framework benefited greatly by being deeply rooted in nine foundational principles based on FIPs, including openness and transparency, purpose specification, collection limitation and minimization, use limitation, individual participation and control, data integrity and quality, security safeguards and controls, accountability and oversight, and remedies.⁶

Government initiatives have also used FIPs to guide information-sharing efforts for almost 40 years, and the Department of Commerce recently recommended that they be used to protect online consumers.⁷ It is essential to apply them upfront, in a thorough and comprehensive manner, when contemplating any new information sharing.

Because of ACOs' inherent dependence on information sharing, establishing trust with patients will be key to engaging them in this new information environment.

What policies and practices should an ACO implement to support patient trust? We raised this question as a group to explore the specific context in which ACOs will arise.

As we have discussed, ACOs require more robust information sharing than most providers have engaged in historically, including the following:

- ACOs will receive patient-identifiable claims data from CMS, including claims for providers outside of the ACO.
- ACOs will likely exchange more information among providers both within and outside of their walls.
- ACOs will exchange information with patients.

It is important to note that the ACO program will be implemented at a time when Internet privacy concerns have been heightened as consumers are increasingly learning through media stories how their personal information is used without their knowledge.⁸

⁶ Markle Connecting for Health. *Common Framework: The Architecture for Privacy in a Networked Health Information Environment*. 2005. Accessed on the Web May 25, 2011: http://www.markle.org/sites/default/files/P1_CFH_Architecture.pdf.

⁷ Department of Commerce Internet Policy Task Force. *Commercial Data Privacy and Innovation in the Internet Economy: A Dynamic Policy Framework*. 2010. Accessed on the Web May 25, 2011: http://www.ntia.doc.gov/reports/2010/IPTF_Privacy_GreenPaper_12162010.pdf.

⁸ For example, see the *Wall Street Journal's* "What They Know" series, available at <http://online.wsj.com/public/page/what-they-know-digital-privacy.html>.

ACOs' strong commitment to patient engagement provides an excellent basis for a commitment to transparency and education.

While CMS recognizes that much of the information sharing required by ACOs will be covered under HIPAA through the TPO exception,⁹ the recommendation to provide beneficiaries with a meaningful choice about whether CMS can share their claim information with an ACO provider is consistent with the FIPs principles of transparency and participation. By simply offering patients the choice not to have their claim data from CMS shared, it seems to provide no major additional or unnecessary burden on providers.

However, concerns have been raised as to whether this will disadvantage the outcomes an ACO will be able to achieve and whether it will undermine patient safety. We believe this potential impact is worthy of study and analysis in the initial implementation period in order to determine the validity and scale of this concern. It is also important to understand how often patients will chose to opt out of having their information shared and under what conditions they will agree to allow it. From an analysis and research perspective, this policy element is as important a part of a successful ACO experiment, as are the elements related to reimbursement changes. A commitment to study these open questions and to address them in a timely manner will be possible if the program assumes this need and enables CMS and participating providers to learn and reevaluate requirements rapidly, based on studying and sharing analysis of objective data in an ongoing way.

Consistent with our recommendations above regarding the need for a full framework to be applied, other elements of the FIPs framework should apply beyond individual choice, including policies to limit data collected and used to that which is necessary to support patient care, audit, and strong security practices.

D. Engage patients through improved access to their health information

ISSUE: Empowering patients and their families by engaging them directly with their own information can enhance communication between patients and medical professionals.

RECOMMENDATIONS:

1. We commend CMS for requiring ACOs to offer patients access to their health information, including access to a care summary and care plan.
2. Moving forward, ACOs should offer patients the ability to view and download their health information and require ACOs to share information routinely with patients.
3. CMS should also explore how it can leverage its own download capability provided to beneficiaries on MyMedicare.gov to bolster ACO efforts.

⁹ The TPO exception refers to the ability to use and disclose protected health information (PHI) without an authorization or without having to obtain a Waiver of HIPAA Authorization when the use and disclosure falls within treatment, payment, and health care operations activities.

RATIONALE: According to the Markle Survey on Health in a Networked Life 2010, roughly 2 in 3 of the public and doctors surveyed agree that people should be able to download their personal health information.¹⁰

A broad vision for patient engagement should guide the criteria for patient centeredness and assessment of beneficiary and caregiver experience for the Medicare Shared Savings Program. We articulated similar recommendations in Markle Connecting for Health collaborative comments to HHS on the draft Meaningful Use rule,¹¹ which applies fittingly to the Medicare Shared Savings Program. These recommendations include the following:

- Consider individuals as information participants—not as mere recipients, but as information contributors, knowledge creators, and shared decision makers and care planners.
- Shift paradigms so that information is not provided to individuals only upon request, but is delivered routinely after every visit in a format that matches the individual’s needs and wishes.
- Encourage the extension of communication and feedback cycles among individuals and care teams beyond episodic, office-based encounters.
- Enable individuals to compile copies of their information on a timely basis and share it in the manner of their choosing.
- Research and develop new patient engagement performance measures that are directly tied to health improvement goals.

Meaningful Use Stage 1 already includes key requirements to facilitate individual access to personal health information, and these requirements should be baseline elements for providers participating in ACOs. Patient-centeredness criteria for the Medicare Shared Savings Program should similarly enable individuals to securely access their information electronically and include an option for individuals to view and download their own information with sound privacy and security policies and practices in place, in ways that enable individuals to use and share their own information as needed and desired.¹²

The formats of downloadable information provided to patients can begin with flexibility as long as it is human-readable. Other options for commonly used software formats such as text,

¹⁰ Markle Foundation. *New Markle Survey Finds US Public and Doctors Alike Support ‘Blue Button’ for Downloading Health Information*. October 7, 2010. Accessed on the Web May 25, 2011: http://www.markle.org/downloadable_assets/20101007_bluebutton_pr.pdf.

¹¹ Markle Connecting for Health. *Comments on the Centers for Medicare and Medicaid Services’ Notice of Proposed Rulemaking for the Electronic Health Record Incentive Program*. March 15, 2010. Accessed on the Web May 25, 2011: http://www.markle.org/downloadable_assets/20100315_ehrincent_cms0033p.pdf.

¹² Markle Connecting for Health. *Common Framework for Networked Personal Health Information, Policies in Practice: The Download Capability*. August 2010. Accessed on the Web May 25, 2011: http://www.markle.org/downloadable_assets/20100831_dlcapability.pdf.

spreadsheet, or PDF, as well as the standardized clinical summary formats required under Meaningful Use (i.e., CCD or CCR) can be offered provided that they are always delivered in a human-readable format as well. These options are essential to engage people with varying needs, wishes, and technology sophistication. They also enable innovation in services that can add value to the downloadable data with the individual's permission, including emerging mobile applications. Critically, the bottom-line requirement for human-readability ensures that people will not need to use a specific application or service in order to see their own health information.

In addition to supplying the information to individuals in human-readable formats, ACOs should be encouraged to provide an option for individuals to download the information available in whatever clinically codified languages or structured formats their systems use. That way, consumers may make use of their information in separate applications of their own choosing, which may be able to consume specific clinical codes sets and controlled vocabularies for richer functionality or decision support. In order to engage patients, it will be critical that ACOs communicate and share information with patients through tools that are familiar and easy to use. Many times, for example, underserved communities face obstacles when trying to engage directly with their own information because of limited access to a computer either at home or at work. CMS is in a position to share best practices to help ACOs tackle challenges of access, usability and literacy to help them improve care for all of their patients.

CMS should also explore ways to make use of its own blue button capabilities, which enable beneficiaries to securely access and download their own information on the MyMedicare.gov website. Downloads from CMS's portal can be integrated into applications that aim to help patients make use of this information to manage their health. These tools could be leveraged by beneficiaries participating in ACOs if used to this end.

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