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Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3276–NC
P.O. Box 8013
Baltimore, MD 21244–8013

Farzad Mostashari, MD
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Suite 729-D
Washington, D.C. 20201

Re: Advancing Interoperability and Health Information Exchange, CMS–0038–NC

Dear Ms. Tavenner and Dr. Mostashari:

On behalf of the members of the EHR Association (the Association), we are pleased to submit our comments on the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS) *Request for Information (RFI) on Advancing Interoperability and Health Information Exchange*. Our response was developed through an open, collaborative process that engaged representatives from our member companies which represent the majority of installed, operational EHRs in the US. On behalf of these companies and our collective customers – hospitals and physicians of varying sizes and specialties – we have responded to the policy options and questions posed in the RFI that are relevant to EHR vendors in general.

We want to emphasize that the Association is highly supportive of enhanced levels of interoperability and health information exchange (HIE), and we appreciate that ONC and CMS are exploring additional policy options towards this end.

Section 1: Policy Issues

Issue 1: Low rates of EHR adoption and HIE among post-acute and long-term care providers [78FR14795]

The RFI identifies potential policy options in this area and we comment on several of these:

Authority to allow states to implement innovative delivery and payment models for Medicare/Medicaid beneficiaries.

1. Authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and CHIP.

   In general, we believe that it would be worthwhile for CMS to implement and test innovative models for delivery and payment that encourage care coordination and the use of medical homes, which in turn will drive demand for and benefit from effective cross-continuum health information exchange.

2. Cost allocation policy for developing and sustaining HIE infrastructure - states may be eligible for 90% federal financial participation.

In general, we support states expanding their HIE infrastructures using matching federal funds available from Medicaid. We encourage such work to be closely coordinated with nationally-adopted standards and policy approaches in such areas as interoperability, patient privacy, and identity matching to enhance the prospects for success as well as efficient and effective vendor support.

Issue 2: Low rates of HIE across settings of care and providers [78FR14796]

The RFI identifies potential policy options in this area and we comment on several of these:

1. Collaborate in the development of new e-specified measures of care coordination.

Although we strongly support both care coordination and effective clinical quality measures, we do not believe that development of new e-measures for care coordination is necessarily warranted or the best means to encourage or assess care coordination. A focus on new process measures rather than outcomes runs the risk of driving providers to engage in activities to meet specific measures rather than to focus on good outcomes. We believe that more consideration is needed about where new outcomes based e-measures or other ways to track outcomes outside of the e-measure framework are the most feasible and cost-effective means to encourage and track care coordination.

2. Consider news ways to require or encourage Medicare ACOs to exchange health information.

We strongly believe that the current Medicare ACO models will encourage exchange of health information to support the intermediate and final outcomes sought by ACOs – including care coordination, patient engagement, high measured quality, patient satisfaction, and cost performance. One of the very positive aspects of the current ACO regulations is that they are fairly non-prescriptive and focus on outcomes thus creating an organic and effective business case for exchange of health information. We think that it would be premature and counterproductive to force ACOs into engaging in exchange beyond what the unfolding dynamics of this model provide for.

3. Authority to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or CHIP expenditures while maintaining or improving the quality of care for beneficiaries.

We are generally supportive of CMS using its authority to test different payment and delivery models. We further believe that requesting applicants to explain how they will use technology to advance health information exchange makes sense, but urge that the focus is on the "why" of the exchange and not on to exchange itself. We urge CMS to engage EHR developers, standards development organizations (SDOs), and other health IT stakeholders early in development of such models so that requirements align with available capabilities.

4. Testing models to better align the financing of Medicare and Medicaid and integrate care delivery for people who are enrolled in both Medicare and Medicaid, also known as dual eligible.

We are supportive of this general approach but, again, urge a focus on desired outcomes rather than specific technology approaches. In addition, we urge CMS to address the fact that Medicare and Medicaid technology platforms are different, and to recognize the need to take into account these discrepancies as they look to use technology to better coordinate care and reporting on dual beneficiaries.

Issue 3: Low rates of consumer and patient engagement [78FR14796]

The RFI identifies potential policy options in this area and we comment on several of these:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

We support adding questions to the CAHPS survey to assess the extent of effective patient and family engagement and care coordination.

2. Promote use of the Blue Button.

We are highly supportive of healthcare information following the patient and for consumers to have access to their health information. At the same time, we urge CMS and ONC to be clear on the relative roles of the meaningful use view, download, and transmit (VDT) functionality and the Blue Button Plus specifications. We urge that CMS and ONC harmonize and clarify these functions to enable more effective use by both EHR developers and patients and their families, and not create conflicting or duplicative specifications or messages about how to access patient information.

3. Authority to test innovative payment and service delivery models that have the potential to reduce program expenditures while maintaining or improving the quality of care for beneficiaries.

We support this approach. It makes sense for CMS, in future and new payment and delivery models, to encourage applicants to experiment with providing incentives for consumers to more actively participate in their health and healthcare. The focus should be on incentives for participation and not specification of technology approaches.
Although the referenced programs may ultimately have a significant impact on promotion of health information exchange, these programs are still too new to rank or characterize in terms of impact.

However, consistent with our response to Question 1, we *expect* value-based purchasing, ACOs, and the EHR Incentive Programs to yield the greatest impact.

Section 2: RFI Questions

Question 1: What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?

Leveraging the widespread adoption and meaningful use of health IT by providers as established by the EHR Incentive Program, the federal government should implement payment policies that focus on value-based and accountable care. By shifting the payment structure to accountable care and value-based models, where providers must coordinate patient care in order to receive maximum payments by reducing the cost and improving the quality and outcomes of care delivered, barriers to the exchange of health information will be lowered and a business case will exist for the sharing of information.

Question 2: Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

Although the referenced programs may ultimately have a significant impact on promotion of health information exchange, these programs are still too new to rank or characterize in terms of impact. However, consistent with our response to Question 1, we *expect* value-based purchasing, ACOs, and the EHR Incentive Programs to yield the greatest impact.

In terms of the design and implementation of these programs, we find that the *ability* to electronically exchange information isn't necessarily the gating factor. Organizational and reimbursement policy and infrastructure are much more significant issues.

Question 3: To what extent do current CMS payment policies encourage or impede electronic information exchange across health care provider organizations, particularly those that may be market competitors? Furthermore, what CMS and ONC programs and policies would specifically address the cultural and economic disincentives for HIE that result in "data lock-in" or restricting consumer and provider choice in services and providers? Are there specific ways in which providers and vendors could be encouraged to send, receive, and integrate health information from other treating providers outside of their practice or system?

As referenced in response to Question 1, the current fee-for-service model does not provide sufficient benefit to providers for investing in the resources and time necessary to electronically exchange information for the purposes of care coordination.

Although we believe that shifting reimbursement away from volume-driven models to value-based models that could reward care coordination activities, we do not believe the government should be overly prescriptive as to how electronic health information exchange should occur or indeed when electronic exchange should be used relative to other coordination approaches.
Instead, as has been done for 2014 Edition Certification, the government should define clear capabilities at the vendor level to exchange information outside their systems and implement payment policies that create a value proposition and business case for the exchange of health information.

The Association is working on an industry Code of Conduct that addresses the need to avoid data lock-in along with many other issues.

Question 4: What CMS and ONC policies and programs would most impact post-acute, long term care providers (institutional and HCBS) and behavioral health providers' (for example, mental health and substance use disorders) exchange of health information, including electronic HIE, with other treating providers? How should these programs and policies be developed and/or implemented to maximize the impact on care coordination and quality improvement?

It is widely recognized that the inconsistencies in various state and federal privacy laws as they pertain to sensitive health information, such as that protected under 42 CFR Part 2, continue to be obstacles to widespread health information exchange. As suggestions for revisions to these laws, including a mechanism to provide a nationwide, privacy-focused legal framework, are outside of the purview of this Request for Information, we encourage ONC/CMS to continue raising awareness to this issue and implement changes within the CMS and ONC programs to:

- Standardize patient authorization related to the access and exchange of personal health information by providers;
- Encourage the unencumbered sharing of personal health information for treatment purposes among providers participating in an ACO; and
- Recognize the current technical and operational challenges of data segmentation in EHRs and support all reasonable technology solutions that facilitate the exchange of sensitive personal health information based on patient-directed consent.

Question 5: How could CMS and states use existing authorities to better support electronic and interoperable HIE among Medicare and Medicaid providers, including post-acute, long-term care, and behavioral health providers?

In order to support electronic and interoperable health information exchange among Medicare and Medicaid providers, CMS and the states should ensure that the infrastructure across in-state technology platforms is consistent. More importantly, CMS and states should implement consistent policy decisions with regards to the governance of sharing information. Particularly for providers and organizations that operate across state borders, harmonization with other states should be considered as well.

Question 6: How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in overtime? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

No response

Question 7: How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program. For example, could the attestation process capture provider identifiers that could be accessed to enable exchange among participating EPs?

Authentication and identification of providers will be critical to advancing directories that would support trusted and efficient electronic exchange of health information. However, adding the capture of a provider identifier to the attestation process would not meet the complex requirements of such an infrastructure. Additionally, not all providers participate in the EHR Incentive Program and providers already have a National Provider Identity that could be confused with an attestation identifier.

In order to establish a national mechanism for identifying providers that allows multiple directories to be maintained across organizations and geographies, the private and public sector must collaborate to establish standards, a business case, and best practices. Additionally, the healthcare industry would benefit from drawing on the experience of other industries – for example, enterprise email systems that allow for internal communication as well as communication with individuals not using the system.

Question 8: How can the new authorities under the Affordable Care Act for CMS test, evaluate, and scale innovative payment and service delivery models best accelerate standards- based electronic HIE across treating providers?

The new authorities under the Affordable Care Act for CMS can best accelerate standards-based electronic health information exchange across providers by focusing less on intermediate technology approaches, and more on clearly identifying and articulating desired healthcare delivery—quality and outcomes improvement, cost reduction, increased access to care. Health IT should not be considered an end, but rather a means to an end. When providers are paid for value-driven and accountable care, they will be motivated to work with technology vendors to develop functionality that enables care coordination.

Furthermore, the government can accelerate standards-based electronic health information exchange by continuing to foster an environment where interoperability standards can be identified, selected, and matured with private-public and broad stakeholder engagement.

Question 9: What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and program to maximize beneficiary access to their health information and engagement in their care?

CMS and ONC should continue to maximize the investment in patient access and use of the electronic health information resulting from the EHR Incentive Program. Providers can have a significant impact on the behavior of patients, and the EHR Incentive Program encourages providers to increase patient access and use of their health information.

Additionally, we suggest that CMS provides incentives to Medicare and Medicaid beneficiaries for reviewing their problem and medication lists online, verifying medications, and participating in health lifestyle type programs. Not only would financial incentives promote access, but tying those incentives to interaction with the information would help to ensure continued use. Perhaps the government could test beneficiary information access models.

Question 10: What specific HHS policy changes would significantly increase standards based electronic exchange of laboratory results?

Despite advances in EHR technology standards, laboratory service providers do not adhere to the standardized and consistent use of LOINC codes. While the role of EHR vendors is to receive LOINC codes, it is inappropriate to expect EHR developers to map from non-standard code sets to LOINC due to

a lack of expertise among laboratory systems suppliers. By increasing standardization of result delivery using LOINC codes, HHS could significantly increase standards-based electronic exchange of laboratory results. Perhaps the government could implement levers to incent the laboratory systems companies to always send a LOINC code with a lab result, or use regulations to mandate the use of standard codes.

The CMS NPRM "CLIA Program and HIPAA Privacy Rule; Patients' Access to Test Reports," published September 14, 2011, proposed to amend the patient privacy provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and expand the patient right to access health records through enabling direct patient access to test results directly from laboratories. The preamble of the proposed Rule explained that providing direct patient access to lab results would support our national commitments and goals regarding the widespread adoption of EHRs, robust health information exchange, and greater patient engagement in healthcare. We support CMS' activities toward finalization of this Rule.
Again, representing our members and our customers, we appreciate this opportunity to provide comments on this important initiative and look forward to working with ONC and CMS to enhance the levels of interoperability and health information exchange nationwide.

Sincerely,

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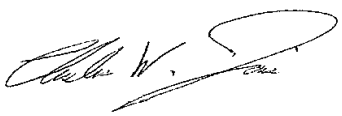

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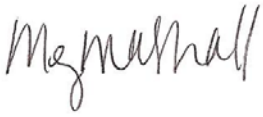

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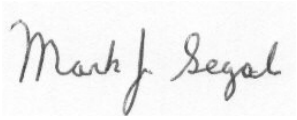

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About HIMSS EHR Association

HIMSS EHR Association is a trade association of Electronic Health Record (EHR) companies that join together to lead the health information technology industry in the accelerated adoption of EHRs in hospital and ambulatory care settings in the US. Representing a substantial portion of the installed EHR systems in the US, the association provides a forum for the EHR community to speak with a unified voice relative to standards development, the EHR certification process, interoperability, performance and quality measures, and other EHR issues as they become subject to increasing government, insurance and provider driven initiatives and requests. Membership is open to HIMSS corporate members with legally formed companies designing, developing and marketing their own commercially available EHRs with installations in the US. The association, comprised of more than 40 member companies, is a partner of the Healthcare Information and Management Systems Society (HIMSS) and operates as an organizational unit within HIMSS. For more information, visit http://www.himssehra.org.