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On behalf of the member companies of the HIMSS Electronic Health Record (EHR) Association, which collectively have unparalleled experience in developing and deploying EHRs in hospitals, physicians' practices, post-acute care organizations, and more, we offer our comments on the Department of Health and Human Services' (HHS) Center for Medicare and Medicaid Services (CMS) Notice of Proposed Rule-Making (NPRM) on Accountable Care Organizations (ACOs).

Although there are several areas where CMS seeks input, this letter will primarily offer comments concerning the electronic health records (EHR), health IT, and health information exchange (HIE) references in the NPRM. Additionally, we will offer suggestions related to areas of the ACO program where health IT should have, in our opinion, a greater emphasis in the final rule.

ACOs represent one of the first real steps to building a new value-driven healthcare system to address the critical shortcomings in the current payment model. However, we share the concerns of many industry stakeholders that the ACO Shared Savings proposed rule, as currently formulated, will substantially limit initial participation by constraining the ability of ACOs to invest in needed infrastructure and to operate effectively given the relatively high risk/reward ratio. ACOs, if established properly, can deliver better care for individuals, better health for populations, and lower growth in healthcare-related expenditures, and the EHR Association strongly supports the key frameworks that will enable success within the ACO concept, including care coordination between providers, patient-centered care, the use of evidence-based medicine, and the general concept of quality measurement and reporting.

Following are our comments and recommendations:

<u>The Role of Health Information Technology</u>

Health information technology – through electronic health records and health information exchange – will be critical to the success of Shared Savings ACOs and to their meeting the goals of practicing evidence-based medicine, care coordination, quality measurement, and patient centeredness. We were pleased to see that CMS – throughout the NPRM – encourages a largely non-prescriptive approach to health IT that would permit locally appropriate decision-making by the ACOs with a primary focus on outcomes. However, while still allowing for flexibility, we believe that ACOs should be very strongly encouraged to implement EHR technology to meet their needs for robust core clinical systems – ideally, HITECH-certified EHR technology.

The proposed rule suggests that 50% of the primary care providers in an ACO must demonstrate that they have satisfied the requirements of the meaningful use program by their second year of participation. However, given that the program is still in its early stages,

with minimal feedback to date, and many physicians in the country's smaller practices are still determining their strategy for participation, this high threshold could be prohibitive and may reduce interest in the ACO program.

Therefore, we recommend that CMS require a lower threshold of 25% among all Eligible Professionals (EPs) as defined under the meaningful use program – not just primary care providers – while also requiring each ACO to commit to measurable improvement and tracking of meaningful use participation in the future. It is critical that ACOs understand that CMS expects the full potential of health IT to be applied to this challenge by requiring demonstration of adoption and use during the application process, and it is our belief that the meaningful use threshold – while imperfect – is one method of doing so.

CMS must encourage the use of health IT by *all* providers that are members of an ACO – not just primary care providers – in order to advance HIE, remove information silos that potentially compromise quality care, and encourage true reform in care delivery to better meet the needs of patients and other consumers.

Health Information Exchange: Care Coordination

There are numerous references to HIE within the ACO Shared Savings NPRM. It's clear that the care coordination critical to ACO success will require robust, bi-directional, query-based approaches to accessing all patient data – clinical, administrative, financial, and process. In today's healthcare environment, however, "health information exchange" is increasingly recognized as a verb, not just a noun. We recommend that CMS be clear to ACOs that they have the flexibility to use any standards-based electronic care coordination tools that meets their needs. Specifically, we recommend that CMS indicate that the language within the rule about HIE is supportive of the *concept* of the electronic exchange of health information rather than a particular type of organization or infrastructure facilitating that exchange.

The approach an ACO takes to establishing effective clinical data exchange should not only be standards-based, but capable of exchanging data with authorized providers inside and outside of the ACO structure, as is determined necessary to achieve the goals of the program. The ability to facilitate information exchange among affiliated and unaffiliated providers through the use of interoperability standards is an important ingredient in the success of ACOs.

Lastly, it is important for HIE to provide real-time and clinically-rich data for care provided outside of the ACO as a supplement to the monthly Medicare claims data that CMS proposes to provide.

Financial Benchmarking

In the NPRM, CMS proposes to exclude incentive payments earned through participation in the meaningful use EHR incentive program, as well as other incentive payments made to Eligible Professionals, from the ACO benchmark and actual expenditure calculations. We applaud this approach, as we believe that incentive payments earned through health IT adoption under other programs should not impact any shared savings targets. But we strongly recommend that the same exclusion be applied to Eligible Hospitals (EHs) who have participated in the meaningful use program or other incentive programs. To determine a Minimum Savings Rate or calculate any shared savings without first removing such incentive payments from the computation

significantly lowers the benefit of participation in the ACO program by those hospitals. Any policy that would hamper a provider's ability to take full advantage of all available federal incentives, even when they meet standards and demonstrate positive program outcomes, runs counter to the intent of such programs and could clearly have a negative impact on participation.

Quality Measurement Alignment

We strongly urge CMS to align reporting initiatives so that healthcare organizations do not need to generate and submit duplicative information using different reporting specifications. Our customers – hospitals and physicians' practices across the country – have reporting requirements for a number of programs, including the ePrescribing incentive under the Medicare Improvements for Patients and Providers Act (MIPPA), the EHR Incentive Program, Physician Quality Reporting System, Joint Commission Core Measures, quality initiatives that are part of the CMS Hospital Value-Based Purchasing Program, and others.

In addition to considering the burden placed by these multiple programs on the provider community, we also ask that CMS be cognizant of the impact on the software developers. EHR vendors must accommodate each variation in quality measurement even if the differences do not demonstrate additional clinical value. And if the measures change frequently over time but not in any organized or coordinated way, an undue burden is placed on the vendors, and by extension on their provider customers, who must deal with multiple updates and software versions. Further, if quality measure specifications are not the same as those in existing programs (or those proposed), it will be difficult for EHR vendors to analyze, design, build, test, and release the necessary tools to allow organizations using our software to capture and report on the data needed for the measures by January 1, 2012. It will also be very difficult for healthcare organizations to design, plan, and implement necessary workflow changes (much less train their users to capture the data appropriately) within this short timeframe.

Additionally, much emphasis is placed on the Group Practice Reporting Option (GPRO) tool as a solution to the reporting requirements within the Shared Savings Program. We request that CMS expedite its thinking on linking the GPRO tool to EHRs as part of the general movement toward e-measurement and e-data collection through EHRs and other health IT.

The Quantity of Quality Measures

Given the short timeline for the start of the Shared Savings Program, we believe that capturing data for and reporting on 65 quality measures in the first year of participation is not a realistic goal, and we urge CMS to reduce this number. For comparison, the Physician Quality Reporting System requires three measures per provider, and meaningful use Stage 1 involves reporting on either six measures (for EPs) or 15 measures (for EHs). Value-Based Purchasing for Hospitals, one of the building blocks of accountable care, requires 12 measures and eight survey measures in the first year that already have been active for at least one year prior to adoption. In total, there are currently more than 200 different measures in place across various programs. The burden here is clear.

Thus, we suggest reducing the number of quality measures in the Shared Savings Program to 20 or fewer, and utilizing the same measures across multiple programs wherever possible.

Finally, we applaud the fact that the first year of the ACO program, like that for meaningful use, requires only calculation of the measures, followed by an evolution to payment based on full and accurate outcomes in subsequent years.

Program Governance and IT

Given the importance of IT to the successful attainment of goals specified in the program, and the clear fact that ACOs will need to implement EHRs and other health information technologies to achieve their needs (and specifically HITECH-certified technology), we recommend that CMS ask applicants to address their plans to manage the IT needs of the ACO within their application and governance plan. The goal is to require the applicant to articulate a clearly-defined strategy to support the program's outcomes through the use of health IT.

Additionally, we recommend that there be requirements within the ongoing governance process for reporting on how each ACO has satisfied the program's requirements. This will deliver another form of accountability for the program to ensure sufficient value for the tax payer investment and that the country truly achieves the benefits envisioned.

We appreciate the opportunity to provide input to this important program, and look forward to an ongoing dialog with regulators on health IT-related topics. Our companies collectively represent not only our customers and employees, but all of us as consumers of healthcare services. We want to work collaboratively to ensure that all those interests are considered.

Sincerely,

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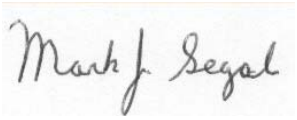

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About HIMSS EHR Association

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.