eHEALTH INITIATIVE

Real Solutions. Better Health.

June 6, 2011

Dr. Don Berwick
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS–1345–P, Medicare Program: Medicare Shared Savings Program: Accountable Care Organization

Submitted via http://www.regulations.gov

Dear Dr. Berwick,

eHealth Initiative welcomes the opportunity to comment on the Medicare Shared Savings Program Accountable Care Organization Proposed Rule.

eHealth Initiative (eHI) is an independent, non-profit, multi-stakeholder organization. Its mission is to drive improvements in the quality, safety and efficiency of healthcare through information and information technology (IT). eHI advocates for the use of health information technology (HIT) that is practical, sustainable and addresses stakeholder needs, particularly those of patients. The comments below were developed through our multi-stakeholder consensus process.

eHI commends CMS, along with your other federal government colleagues, for developing the proposed rule for the Medicare Shared Savings Program for accountable care organizations (ACOs). Section 3022 of the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA), as amended, directs HHS to implement an integrated care delivery model in Medicare and use Accountable Care Organizations (ACOs), as the model.

We applaud your efforts to develop a model that addresses the health of people, the health of populations, and the need to slow the growth of healthcare costs, while simultaneously incentivizing less fragmentation in care delivery through a

818 Connecticut Avenue NW Suite 500 Washington, D.C. 20006
Tel: 202.624-3270 Fax: 202.429.5553
www.ehealthinitiative.org

voluntary program that allows flexibility to participating organizations. The goal is laudable and we want the ACO model to be as successful as possible.

Although there are several issue areas where CMS seeks comment, this letter will primarily offer comments concerning electronic health records (EHR), HIT, and health information exchange (HIE) references in the Proposed Rule. Additionally, we offer comments on those instances in the Proposed Rule where we believe HIT and HIE should have a greater emphasis, in order to support the five domains for assessing, benchmarking, rewarding and improving ACO quality performance, as listed on page 19570, that support the requirements of section 1899(b) (3) of PPACA:

- Patient/Caregiver Experience
- Care Coordination
- Patient Safety
- Preventive Health
- At-Risk Population/Frail Elderly Health

Before offering specific comments, we offer our perspective on the factors in the healthcare environment that provide the context for the comments that follow:

1. HIE Is A Key Enabler for Successful ACOs

eHI supports the Medicare program use of the ACO concept as an example of the federal government leveraging its existing programs to support expanded use of and demand for the exchange of information among providers and individuals. In our April 29, 2011 comment letter to the Office of the National Coordinator for Health Information Technology (ONC) on the Federal Health IT Strategic Plan, we cited the importance of viewing the investment in HIE as akin to the creation of the Interstate Highway system. Therefore, the value of HIE extends beyond the parameters of the EHR Incentive Program. While there is variation in the approach or architecture of health information exchange, the ability to facilitate information exchange among affiliated and unaffiliated providers and their patients, through the use of interoperability standards, is an important ingredient in the success of ACOs. HIE can be a strong component of the ACO to make critical linkages among the patient and their care community.

2. Maintain a Balance Between Offering Flexibility and Being Prescriptive

In a voluntary program that is intended to stimulate learning about revisions to healthcare delivery and payment redesign, we commend CMS for encouraging a non-prescriptive approach to HIT that permits variation among ACOs and focuses on outcomes and achievement of the program goals. We also recognize the critical importance of eliminating silos of information by promoting widespread use of

health IT. As such, the rule should incentivize the use of Health IT to achieve better outcomes.

This flexibility will facilitate ACO testing of different approaches based on the needs of their specific provider and patient population. It also has the potential to encourage ACOs to deploy solutions in the healthcare market that are innovative and have the potential to grow in market relevance. We urge CMS to work with ONC to ensure that the timing of, and requirements for, standards-based electronic exchange of health information is implementable by the ACO. The timeframe and priorities of the ACO program need to be supported by the expanding information exchange infrastructure.

Finally, while we agree with the non-prescriptive approach to HIT, we believe that ACOs should be encouraged to implement meaningfully used technologies, standards-based HIE, and interoperability necessary to support the goals of the ACO program such as better care coordination.

3. Harmonize Requirements with Other Delivery Redesign Programs

The Medicare Shared Savings Program is anticipated to be one of multiple ACO programs introduced by CMS. The recent introduction of the Pioneer ACO Program is noted as the most recent model utilizing the accountable care concept. We request that CMS harmonize requirements as feasible among other federal accountable care programs, particularly a Medicaid ACO program, policies developed by the Federal Coordinated Health Care Office, and coordinate with private sector ACOs. CMS should align timelines and outcome measures as feasible, while recognizing that alignment does not always mean equivalence and that the Medicare Shared Savings program will likely target a smaller pool of providers than may be the case in other initiatives, such as the EHR Incentive Program.

4. Facilitating Ongoing Improvement by ACOs

To improve the success of ACOs in this program and others, we encourage CMS to share data collected from ACOs in a manner that supports ongoing evaluation of ACO performance and enables continuous improvement.

5. ACO Management of HIT Needs

The proposed rule provides specificity in several aspects of the governance of an ACO. Given the importance of HIT to the successful attainment of goals specified in the program, we recommend that CMS ask applicants to address their plan to manage the HIT needs of the ACO. Consistent with the flexibility provided to ACOs, a description of the leadership and plan for HIT issue management should suffice. We applaud the fact that the selection factors for the Pioneer ACO Model include

opportunities for the applicant to identify HIT leadership and the HIT infrastructure and functions. The goal of our request, in the context of the Medicare Shared Savings Program, is not to add to the governance requirements, but provide the applicant with an opportunity to articulate their strategy to support the program outcomes through the use of HIT. This plan also offers an opportunity for the ACO to articulate how, if at all, they intend to utilize health information exchange.

6. Quality Measure Requirements in the ACO and Other CMS Programs
CMS should align the quality measures selected for the ACO program and other CMS programs, yet recognize that alignment does not necessarily mean that the same measures must be used in all programs. We applaud the recognition in the Proposed Rule that if an eligible professional affiliated with an ACO satisfies the ACO quality reporting requirements, they also will satisfy will be deemed to satisfy the Physician Quality Reporting System (PQRS) requirements. In other instances, ACOs may have data collection capabilities and needs that are broader than those applicable to the EHR incentive program. As mentioned in an earlier context, the pool of provider participants in the ACO program will be different than the eligible providers participating in the EHR Incentive Payment Program. Therefore not all meaningful use measures should be adopted in the Medicare Shared Saving Program. In addition, any alignment efforts must take into account problems within the existing programs. The difficulties encountered in other programs should not be transplanted into the Medicare Shared Savings Program. For example, the use of the Group Practice Reporting Option (GPRO) tool, as currently deployed, provides feedback more than one year after the care is delivered. This delay will not support the needs of ACOs to demonstrate improvement in care delivery and cost containment in a short period of time.

While the EHR Incentive Program emphasizes the use of EHRs, HIE, and other HIT by individual providers, the ACO program is a program that also focuses on population outcomes. We urge CMS, in the long-run, to look at team-oriented measures in addition to measures that are very specific to one provider caring for one patient. This approach will help lead us outcome measures that reflect the work of multiple participants of the care team.

To the degree that e-measures are available for use by the ACO quality measure set, we appreciate their inclusion via the GPRO tool and ultimately EHR-based reporting, recognizing that other clinically focused reporting will start with claims data. We encourage the general movement toward e-measurement and e-data collection through EHRs and other HIT, and e-measures that are meaningful and useful should be used. We note that systems used to ensure that e-measures are valid, reliable, and feasible are nascent and the processes are still maturing. Field-

testing of measures is especially important to ensure that needed data fields are, in fact, available in the EHR. For those quality measures that would be computed by EHRs, either as a primary mode of submission or for internal use and development of data for submission; and for which there are e-measure specifications, we urge CMS to work with ONC on development of test methods that vendors could use to establish the accuracy of their quality measure computations, perhaps through testing against a set of standard patient data. Systems also must be in place to ensure that routine updates to measure specifications are communicated to vendors and providers in a timely fashion and incorporated into EHRs in an orderly, predictable manner. We also encourage CMS to continue to work with public and private sector initiatives to articulate the prioritized roadmap of measures that should be made e-measures, with particular emphasis on developing the capacity to collect measures of outcomes, functional status, patient engagement, and care coordination, using patient-reported data wherever applicable and as possible. At the same time, we support the use of survey data or claims data for reporting purposes by ACOs as a starting point for this program. We also urge CMS to work closely with HIT vendors on a process to link EHRs and other HIT with the GPRO tool, if it is used. A requirement at this time that all quality measures reported by the ACO are e-measures, reported from EHRs, could negatively impact the ability to support the assessment of quality performance for all domains and would not be applicable for many measures of patient and caregiver experiences. We encourage CMS to prioritize the establishment of standards for survey data, and the surveys must allow for flexibility in reporting approaches.

7. Safety Net Providers

We appreciate your efforts to incentivize participation by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in the ACO. As you note on page 19538 of the Proposed Rule, they play a "critical role in the nation's health care delivery system, serving as safety net providers of primary care and other health care and social services in rural and other underserved areas and for low-income beneficiaries, including those dually eligible for Medicare and Medicaid." Although the FQHCs and RHCs are not able to form their own ACO under the Shared Savings Program, we are encouraged that the Pioneer ACO Model will permit, and encourage, applications from ACOs led by FQHCs. We recommend that the Shared Savings Program learn from the experience of the Pioneer ACO Model program and incorporate the best practices into the Shared Savings Program.

8. ACO Access to Data on Beneficiary Use of Healthcare Services

eHI supports the provision of Part D prescription drug claims data to the ACOs. Although not part of the overall spending calculation within the Medicare Shared Savings Program, having access to this data will help ACOs meet their goals and

the quality performance metrics included in the care coordination, preventive health and at risk population domains.

Specific Comments

1. Processes to Promote Coordination of Care (page 19547):
Many of the approaches that an ACO may use to coordinate care will involve health information technology, including electronic health records, remote patient monitoring and electronic health information exchange to enable the provision of a beneficiary's summary of care record during transitions of care, both within and outside of the ACO. We recommend that CMS clarify that this language is intended to support the electronic exchange of health information, rather than a particular type of organization to enable that exchange. Health information exchange is a noun as well as a verb, and CMS is encouraged to signal to ACOs that they should have the flexibility to use the approach that best meets their needs. At the same time, ACOs and their patients will likely benefit from the use of robust bi-directional capabilities that extend beyond such modes as secure e-mail, so that ACOs choose to either establish an ACO-wide HIE organization and/or join a community or regional HIE. Approaches to HIE should be standards-based and should be designed to exchange data with authorized parties that are outside of the ACO structure, as the ACO determines what is needed to achieve the goals of the program.

We also recommend that CMS clarify the definition of term "telehealth" in the Final Rule, particularly whether the definition includes a combination of EHRs and HIE (noun and verb), that enable the sharing and receipt of summary of care records, care plans and patient/clinician shared decision-making.

2. Integration of Community Resources into the ACO (page 19550):
The proposed rule calls for a process that integrates community resources into the ACO as an important element of ACO patient centeredness. A wide variety of organizations, not necessarily clinicians or medical providers, may be considered a community resource. eHI supports the notion of an inclusive care team with participants from clinical, educational, prevention and intervention organizations that provide the necessary support to Medicare beneficiaries and their families. It is our view that the inclusion of community resources, as broadly defined, advances the goals of the National Strategy for Quality Improvement in Health Care and other initiatives aimed at improving the care of individuals, improving the health of populations, along with reducing costs.

3. Incorporation of Other Reporting Requirements, such as the Physician Quality Reporting System under the Shared Savings Program

[**Meaningful Use Threshold Requirement for ACO Primary Care Providers]** (page 19600):

We believe that it is important that all physicians within the ACO use HIT in order to fulfill the goals of the ACO: care coordination, improvements in quality, engagement of patients, and reduction of costs. The proposed rule seeks comment on the establishment of an EHR adoption threshold of 50 percent for primary care providers. We do not agree with this proposal. A high threshold, absent evidence of trends in adoption of certified EHRs in stage 1 meaningful use, may hinder primary care provider participation in the ACO. We recommend that CMS measure the estimated provider use of EHRs at the time of the program launch as a baseline, require ACOs to track this information, and establish the expectation that a future threshold will be set and increase over the period of the ACO program. We are concerned about the lack of adequate measures to judge the success of ACOs, including the use of HIT to fulfill the goals of ACOs. Therefore, we encourage CMS to work with stakeholders to adopt measures appropriate to judge the success of ACOs. Additionally, we strongly encourage CMS to promote the use of health IT by all providers that are members of an ACO in order to advance health information exchange, remove information silos, and better meet patient needs.

4. **Technical Adjustments to the Benchmark: Impact of Bonus Payments and Penalties on the Calculation of the Benchmark and Actual Expenditures** (page 19609)

It is essential that CMS take every possible step not to include hospital HIT and value-based purchasing (VBP) incentive payments into the benchmark and spending estimates for hospitals; following the same exclusion approach that it proposed to apply to physicians and other Eligible Professionals. Penalizing ACOs for hospital HIT or VBP incentives runs directly counter to the intent of the HIT incentive and ACO programs. As CMS states, when referring to Eligible Professionals, "We believe that excluding these costs and savings will reduce the chances that incentives that were intended to encourage and reward participation in one Medicare program would discourage full participation in another."

Concluding Comments

The transformation of our healthcare system to one that uses information and information technology to engage patients and their caregivers, improve the coordination of healthcare and achieve better health outcomes for people and populations, while containing costs, is a task whose time is at hand. eHealth Initiative appreciates the opportunity to comment on the Medicare Shared Savings

Program Accountable Care Organization Proposed Rule. We look forward to working with you on programs that support a value-driven and patient-centered healthcare system

Sincerely,

Jennifer Covich Bordenick
Chief Executive Officer
eHealth Initiative