April 22, 2013

Ms. Marilyn Tavenner
Acting Administrator, Chief Operating Officer
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Department of Health and Human Services
Office of the National Coordinator for Health Information Technology

Attention: Interoperability RFI
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave., S.W.
Washington, D.C. 30301

RE: Request for Information: Advancing Interoperability and Health Information Exchange

Dear Ms. Tavenner and Dr. Mostashari:

I am writing on behalf of the Alliance for Home Health Quality and Innovation (the "Alliance") in response to the **Request for Information: Advancing Interoperability and Health Information Exchange ("RFI").**[1] We appreciate the opportunity to provide comments on this RFI, and are pleased that the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) are seeking ways to include long-term and post-acute care providers in health information exchange.

About the Alliance

Founded in 2008, the Alliance is a non-profit 501(c)(3) organization with the mission of fostering research and education on the value that home-based care can provide to patients in the U.S. healthcare system. The Alliance is a member organization comprised of home healthcare providers and organizations dedicated to improving individual patient care and the nation's healthcare system.

The Alliance and its members are keenly aware of the importance of building technological infrastructures which will allow post-acute care providers to work hand-in-hand with other partners across the care continuum to provide high quality, coordinated care. The Alliance membership includes national and regional home health providers, both proprietary and non-profit.

We support health information exchange between home health and other care settings as a means to increase the efficiency of care, lower costs, and improve patient outcomes. Furthermore, we support federal initiatives that would foster health information exchange as described below in this response.

[1] Advancing Interoperability and Health Information Exchange, 78 Fed. Reg. 14793 (Mar. 7, 2013). Available at: http://www.gpo.gov/fdsys/pkg/FR-2013-03-07/pdf/2013-05266.pdf.

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?*

Currently, the Medicare and Medicaid EHR Incentive Programs (the Meaningful Use program), including the allocation of financial incentives, do not include home health and other long-term and post-acute providers.[2] Exclusion from the Meaningful Use ("MU") program has created a lag in the home health community's transition to electronic health records and this lag has prevented many home health providers from fully engaging in health information exchange ("HIE").

Recent research has shown how the lack of financial incentives among ineligible MU providers has undercut their ability to engage in HIE. In a *Health Affairs* article published last year, researchers found that hospitals eligible for MU payments had a 12 percent adoption rate of electronic health records (EHRs) in 2009, compared to adoption rates of ineligible providers at 6 percent for long-term acute care hospitals, 4 percent for rehabilitation hospitals, and 2 percent for psychiatric hospitals.[3] The researchers identified two obstacles to achieving MU that apply to the home health community: (1) provider and vendor uncertainty about what type of EHR system functionality is needed and appropriate; and (2) vendor reluctance to develop resources for ineligible providers.[4] Furthermore, the researchers acknowledged that the lack of MU payments put these providers at a "financial disadvantage." The researchers suggested that this disadvantage could be addressed through financial incentives offered by or through Quality Improvement Organizations, adapting health IT standards and EHR system certification criteria for ineligible providers, and low-interest loan programs.[5]

Other analysis of the MU program similarly recognizes that the cost of EHR adoption remains a significant barrier for providers (drawing from early results showing that only 12.2 percent of eligible professionals had attained MU as of May 2012).[6]

The home health community faces barriers consistent with this research and analysis. Both the lack of incentives and the lack of regulatory standards have curtailed home health's ability to fully engage in HIE with other providers in the care continuum. A 2007 survey of home health's electronic medical systems revealed that only 29 percent of home health care agencies had a basic EHR, and that many of these systems were largely proprietary tools used to process OASIS filings for Medicare billing purposes.[7] Although this survey was conducted six years ago, a recent survey of the Alliance's membership revealed that while roughly one third of our current membership reports the ability to exchange structured and narrative data with other settings, many providers still exchange information in Portable Document Formats (PDFs) or by facsimile. Some have begun to exchange data through physician

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[2] *See* Medicare and Medicaid Programs; Electronic Health Record Incentive Program, 75 Fed. Reg. 44314, 44314 – 44588; *also at* 42 C.F.R. 412, 415, 422 *et al*, Medicare and Medicaid Programs, Electronic Health Record Incentive Program; Final Rule.

[3] Larry Wolf, Jennie Harvel, and Ashish K. Jha. Hospitals Ineligible for Federal Meaningful Use Incentives Have Dismally Low Rates of Adoption of Electronic Health Records. 31 *Health Affairs* 505-13, 508 (March 2012); abstract available online at http://content.healthaffairs.org/content/31/3/505.abstract.

[4] *Id.* at 510.

[5] *Id.* at 511.

[6] *See* Adam Wright, et al. Early Results of the Meaningful Use Program for Electronic Health Records (Correspondence). 368 New England J. Med. 779-80 (Feb. 21, 2013); available online at: http://www.nejm.org/doi/full/10.1056/NEJMc1213481.

[7] Kristine Martin Anderson, et al., *An Environmental Snapshot—Quality Measurement Enabled by Health IT: Overview, Possibilities, and Challenges*, Agency for Healthcare Research and Quality (AHRQ), 6 (July 2012), http://healthit.AHRQ.gov/HealthITENabledQualitymeasurement/Snapshot.pdf.

portals, and there is a strong desire among all of our members to exchange health information with other providers. Still, the lack of funding continues to be an issue that makes it difficult for many providers to fully invest.

Beyond the lack of financial incentives, the lack of health IT standards and EHR system certification criteria for home health has resulted in vendor reluctance to build technological systems that would enable HIE. Although there are private sector certifications for home health EHRs—including the Certification Commission for Health Information Technology (CCHIT)—there are few vendors who have built EHR systems to support HIE for home health. CCHIT's criterion is based on the MU requirements and there are three vendors who are certified to provide EHRs for home health. [8] Of these three vendors, only two products are available on the market. However, even if providers adopted these technologies, the certifications for these products are not federally endorsed. This means that many providers who do invest run the risk that their EHRS may be rendered obsolete should federal standards be adopted at a later time.

Federal support for HIE, by including home health in the MU Program's incentives and standards, would best support the development of a longitudinal EHR for long-term and post-acute care providers. In the absence of incentive payments, the Alliance supports federal health IT standards and EHR system certification criteria to encourage technology vendors to build cross-setting EHRs. We would also support alternative financial incentives offered through Quality Improvement Organizations and low-interest loan programs.

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?*

Provisions relating to Accountable Care Organizations (ACOs), including the Medicare Shared Savings Program, and the MU program have the most direct impact on home health providers. The Final Rule on Accountable Care Organizations retains the MU of EHRs as a quality measure and this measure is "weighted higher than any other quality measure for quality-scoring purposes."[9] This creates an incentive for ACOs to seek out long-term and post-acute care providers that already have the ability to engage in HIE, and excludes non-HIE equipped providers from participating. To the degree that home health providers would like to engage in ACOs and have sufficient funds to invest in HIE, ACOs may act as an indirect means to encourage long-term and post-acute providers such as home health to fully engage.

Similarly, the current proposal for MU Stage 3 from ONC's Health IT Policy Committee would require an electronic exchange of the summary of care record up to 30% of the time for eligible MU providers to other settings of care.[10] The proposed measure specifically addresses the need to provide a summary of

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[8] See https://www.cchit.org/find-cchit, Product: LTPAC EHR, Additional Certification: Home Health. The three vendors are HealthMEDX, AOD Software, and American Data (whose product is Pre-Market) as of April 16, 2013.
[9] *See* CMS's table on the proposed rule versus the final rule, available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/downloads/appendix-aco-table.pdf.
[10] *See* Item # SGRP 303, Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs), available at: http://www.healthit.gov/sites/default/files/hitpc_stage3_rfc_final.pdf.

care record for patients transitioning to "another setting of care **(including home)**" (emphasis added).[11] This measure builds on current requirements that MU providers must transfer electronic summary of care records to other care settings or other providers at least 10% of the time.[12] These requirements, like the ACO measures, encourage MU providers to seek out HIE-enabled home health providers when identifying the most appropriate clinical pathway for a discharging patient.

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 culture 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?*

Our provider members, who are sometimes market competitors, have varied levels of HIE readiness. Those who are not fully equipped have stated that the lack of incentives or regulatory guidance prevents them from investing due to concerns that standards may later be adopted that would render their systems obsolete. While home health providers support HIE and are interested in pursuing interoperability across care settings, providers are looking for federal guidance on health IT standards and EHR system certification criteria. Some of our members have successfully achieved interoperability through individual state HIEs, and more education on engaging in these exchanges could be beneficial for the post-acute care community.

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?*

In addition to the Alliance's comments on programs and policies mentioned above, other programs that would profoundly impact home health's ability to engage in electronic HIE with providers in other settings are the use of e-specified measures and pay-for-performance incentive programs. The Alliance supports the option in the RFI wherein HHS would develop new e-specified measures of care coordination for summary records in transitions of care and use these measures in the CMS quality reporting programs. The work of the Standards & Interoperability Framework ("S&I Framework") through its Longitudinal Coordination of Care Work Group on Transitions of Care has gone a long way towards including long-term and post-acute care providers in the development of a standard Transitions of Care document that can be utilized by home health. The Alliance would support a similar, collaborative effort to develop e-measures that would apply across care settings. Furthermore, the Alliance supports the provision of incentive payments afforded to providers who meet specified HIT standards for HIE.

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 providers?*

[11] *Id.*
[12] *Id.*

In the context of CMS programs that are being designed for dual eligibles, the Alliance supports building incentives to support electronic and interoperable HIE among providers. As stated above, pay-for-performance incentives in the context of such programs would be one way to encourage interoperable HIE. The Alliance would be interested in working with ONC and CMS to explore other means to use both federal and state authorities better to accelerate adoption of electronic health records and HIE.

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 improve 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?*

Many of the tools suggested in the RFI to stimulate HIE across post-acute and long-term care providers are effective tools that the Alliance and its provider members support. In particular, we support: the use of e-specified measures of care coordination to encourage electronic sharing of summary of care records; additional requirements for ACOs that would encourage HIE, and alternative payment and service delivery models that incorporate the meaningful use of EHRs into the model of care.

The Alliance would discourage expanding the current Conditions of Participation for Medicare and Medicaid to require HIE among home health providers. As many home health providers have not fully transitioned to interoperable EHRs, this approach would potentially reduce access for thousands of beneficiaries who currently receive the Medicare and/or Medicaid home health benefits. Additionally, this may unfairly punish providers who have not transitioned to EHRs given restraints such as the cost of developing EHR systems and the lack of regulatory standards to guide long-term and post-acute care EHR development (See Response to Question 1).

Rather than modifying the Conditions of Participation, the Alliance would urge CMS and ONC to consider using alternative policy options to encourage the long-term and post-acute care community to fully engage. Including the use of EHRs in alternative payment and delivery models encourages providers to improve patient care and allows engaged providers to fully test the feasibility of HIE for a provider community that is still in transition. Under the existing MU program, hospitals and eligible professionals were given a period of years to transition to EHRs before penalties take effect. We would ask for a similar approach for long-term and post-acute care providers, such as phasing in any new requirements to give providers time to adjust.

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

The Alliance would continue to encourage the work being done through the Center for Medicaid and Medicare Innovation's Challenge Grant program. For example, the IMPACT Project, funded through a Challenge Grant and based in Massachusetts, has begun piloting an online-based platform that would allow providers who do not have electronic health records ,or have minimal electronic medical records, to send and exchange information with other care providers.[13] This work specifically incorporates home

[13] The two relevant tools from the Massachusetts IMPACT project are the "LAND" (Internet-based "Local" Application for Network Distribution) and "SEE" (Surrogate EHR Environment) interfaces that would allow

health and has been scaled in the S&I Framework's work on Transitions of Care to develop a Use Case that would work across all long-term and post-acute care providers. The IMPACT project is a strong example of an innovative state program that can be scaled to work in larger provider communities. We would encourage additional, new demonstration programs from CMMI that would foster HIE among long-term and post-acute care providers like home health.

Additionally, the Alliance continues to support community initiatives like the S&I Framework, which work with the Health IT Policy Committee and HL7 after collecting critical feedback from providers and experts. We would urge CMS and ONC to continue to use this collaborative as a resource in developing new policies to advance interoperability.

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Thank you again for the opportunity to comment. Should you have any questions about the Alliance's comments, please contact me at 202-239-3671 or tlee@ahhqi.org.

Sincerely,

/s/
Teresa L. Lee, JD, MPH
Executive Director

providers using paper records or EMRs to trade information with other healthcare partners. *See* the IMPACT Project homepage, available at http://mehi.masstech.org/what-we-do/hie/impact/land-and-see.