May 10, 2011

Donald Berwick, MD, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
Submitted electronically

Re: CMS Notice of Proposed Rulemaking for Accountable Care Organizations

Dear Dr. Berwick:

The College of Healthcare Information Management Executives (CHIME) appreciates the opportunity to respond to the notice of proposed rulemaking (NPRM) for Accountable Care Organizations (ACOs).

CHIME's 1,400 members represent chief information officers (CIOs) and other top information technology executives at many of the nation's largest hospitals. CHIME members have frontline experience in implementing clinical systems, and have learned by trial and error what works and what doesn't in implementing such electronic systems and optimizing the value derived from them. Healthcare CIOs share the vision of an e-enabled healthcare system as described by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology.

As it has been described by CMS, ACOs represent the next evolution in healthcare delivery models meant to achieve (1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures. CMS has also articulated the important role data management and technology will play in achieving those ends. However, CHIME believes that further policy examination is needed in several key areas. Specifically, proposals regarding data sharing provisions, Meaningful Use (MU) alignment and assumptions about health information exchange capacities have the potential to undermine CMS goals and ACO effectiveness.

DATA SHARING

CHIME believes the foundations of an e-enabled healthcare system begin with accurate and robust information exchange. Likewise, the success or failure of ACOs hinge greatly on the ability of healthcare providers to exchange data and accurately measure performance. If beneficiary claims data are withheld, the ACO's ability to improve individual beneficiary health, as well as achieve the desired shared savings, could be compromised.

While CHIME understands the importance of allowing beneficiaries to choose their own physicians, we believe that part of a patient-centered, accountable care system is highly dependent on patient accountability. It is often difficult to account for patient behavior in care delivery, but the task of accountable care is made impossible if data is withheld. We believe that allowing ACO patients the ability to opt-out of data sharing, while maintaining their ability to see the primary care physician participating in an ACO, contraindicates efforts to provide accountable care. And while the opt-out proposal is likely to incur fewer problems than an opt-in policy, both fail to reconcile the effect of incomplete data on e-enabled healthcare delivery. This blinded approach does not allow for physicians to have the level of visibility needed to achieve the tenets of ACOs. Further, it could potentially harm providers' ability to deliver quality care and it unnecessarily risks providers' chances of meeting the performance levels needed to qualify for shared savings payments.

RECOMMENDATION: CHIME recommends that if a patient wishes to opt-out of claims data sharing, he or she should be required to see a primary care physician (PCP) not affiliated with an ACO. Alternatively, the ACO-participating PCP could continue to see the patient, but that patient's health care expenditures would not be taken into account in determining whether the ACO is eligible for shared savings or has incurred shared losses. CHIME believes that the first approach would be simpler and more consistent with ACO goals (since data sharing is likely to be immensely important in facilitating care coordination and patient management). In addition, the first approach strikes us as less open to abuse. For example, it avoids situations where certain high-risk or potentially high-cost beneficiaries might be influenced to opt-out of data sharing solely to ensure that their experience will not count against the ACO.

The preceding comments notwithstanding, CHIME wishes to underscore the importance of data sharing to achieve program goals and urges CMS not to provide beneficiaries with an opt-out option relating to data sharing. Beneficiaries would still retain every right to see the physician or other provider of their choice.

MEANINGFUL USE ALIGNMENT

CHIME acknowledges that this NPRM tries to encourage EHR Meaningful Use (MU), and we fully support efforts to incentivize health IT adoption and use. But we believe it is unnecessary to require 50 percent of an ACO's primary care physicians to meet <u>all</u> MU standards by the beginning of the second year of the ACO's agreement with CMS. Certainly, functional information exchange and

College of Healthcare Information Management Executives
4300 Wilson Blvd., Suite 250 · Arlington, VA 22203
Phone: (734) 665-0000 · Fax: (734) 665-4922 · staff@cio-chime.org · www.cio-chime.org

certified EHRs will be important components of ACOs. However, from both patient management and business perspectives, CHIME feels it would not be necessary for an ACO's PCPs to meet all MU requirements. Similarly, CHIME sees no need for CMS to specify some minimum level of EHR MU performance for the hospitals participating in an ACO.

RECOMMENDATION: Rather than mandate a percentage of PCPs and hospitals meet all Meaningful Use objectives, CMS should focus on outcomes, resulting from accountable care. ACOs should be allowed to make decisions based on business requirements to achieve Care Coordination / Information System domain requirements, rather than prescribing MU objectives as necessary to be a participant in an ACO. This recommendation, however, in no way abdicates an ACO's responsibility to provide required performance data. CHIME believes the penalties associated with bypassing Meaningful Use objectives are enough and that some ACOs may be perfectly capable of savings, per ACO goals, without meeting MU.

Another more technical issue relating to EHR MU, especially as the Medicare Shared Savings Program continues, is the need for further definition of which stage of MU would have to be met by the second year of a given ACO's agreement with CMS. For example, if that second year began on January 1, 2014, would CMS expect MU requirements to relate to Stage 1 or to Stage 2? CHIME sees the potential for problems in delineating at what point it might make sense for an ACO's providers/suppliers to achieve a certain level of EHR MU and this further confirms our belief that the ACO regulation is not the place to address this.

SHARED SAVINGS / LOSSES CALCULATION

According to the NPRM, CMS proposes to exclude EHR and other incentive payments made to eligible professionals from the ACO benchmark and actual expenditure calculations. CHIME agrees that incentive payments received through other programs should have no bearing on shared savings targets and applauds CMS for its approach with eligible professionals.

RECOMMENDATION: To this end, however, CHIME strongly urges CMS to apply the same methodology to eligible hospitals. To calculate shared savings, without excluding EHR Incentive Program payments, significantly undermines reasons for eligible hospitals to engage with CMS on this program. A policy that hinders providers' ability to maximize federal incentives, despite meeting standards, is counterproductive for both programs and could have a negative impact on participation.

ACO PERFORMANCE MEASURES

Another issue of concern is the proposed use of 65 performance measures in year one of the ACO program. CHIME is concerned that too many measures are being proposed for the start of the Medicare Shared Savings Program and we urge CMS to reconsider. CHIME also believes that CMS is underestimating the difficulty of its proposed data validation process. For example, it will not be

College of Healthcare Information Management Executives
4300 Wilson Blvd., Suite 250 · Arlington, VA 22203
Phone: (734) 665-0000 · Fax: (734) 665-4922 · staff@cio-chime.org · www.cio-chime.org

easy to obtain copies of medical records for a sample of patients across an entire ACO and then reconcile those records with quality performance data reported by the ACO. This is because these patients are likely to have been seen by several ACO participants and the performance data reported for them could be based on actions taken (and recorded in a patient's medical record) by any one of these participants.

RECOMMENDATION: CHIME recommends that CMS seek to align performance measures across similar or referenced programs and outline a more consistent approach for measuring quality improvement for the parts of other programs that overlap. Comparable performance measures developed through the eRx, PQRI, the EHR Incentive Program, core measures and others should be examined to harmonize and consolidate proposed ACO performance measures.

Likewise, CHIME believes that some measures can be reduced by reexamining which measures are required to align population health and ACOs. For example, immunization and blood pressure treatment are important, but they are not geared towards population health and should not be included as performance measures that ACOs have to report.

If CMS insists on keeping these and other duplicate measures, CHIME believes it would be appropriate for CMS to calculate these and other measures on an aggregated basis, rather than have providers compile and produce report cards. This would be preferable for three reasons.

(1) It would reduce costs to providers, while allowing them to focus on collecting and monitoring in-house measures that will be customized and tailored to specific hospitals, not CMS.
(2) These rules presume most measures can be abstracted from EHRs, but EHRs do not currently generate all data types needed to fulfill the proposed performance measures.
(3) By compiling from providers' metrics, CMS can deter duplicative work by providers and enable broader visibility of the system as a whole.

HIE and OTHER TECHNOLOGICAL ASSUMPTIONS

The NPRM alludes to a number of technologies that will "collect, evaluate, and use data on health care processes and outcomes sufficiently to measure what it achieves for beneficiaries and communities over time and use such data to improve care delivery and patient outcomes." These proposed regulations portend a level of functional health information exchange and technology adoption that may be too aggressive for deployments in January 2012 and not yet ready for effective deployment. For example, the proposed patient centeredness criteria appear to suggest that an ACO must have a patient on-line portal to communicate clinical knowledge/evidence-based medicine to beneficiaries and the ability to electronically exchange information with entities outside of the ACO (not just those within the ACO).

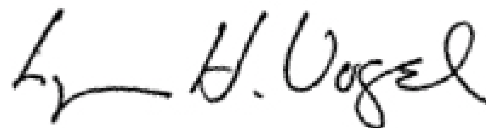
College of Healthcare Information Management Executives
4300 Wilson Blvd., Suite 250 · Arlington, VA 22203
Phone: (734) 665-0000 · Fax: (734) 665-4922 · staff@cio-chime.org · www.cio-chime.org

RECOMMENDATION: As with Meaningful Use alignment, we believe this issue could be better handled by allowing ACOs to determine their own technology needs, given their market and their patient population. CHIME acknowledges that the Shared Savings Program is intended to re-imagine Medicare & Medicaid payment models and it is likely to attract best-of-breed providers. But, we believe that if CMS wishes to have adequate participation in the Shared Savings Program, of the type that can spur widespread adoption of best practices, it would be best to avoid prohibitively high and ambiguous technology requirements that are far from mainstream use. CHIME believes some ACOs may be spurred from large Integrated Delivery Networks. Others will likely be "federated" entities, formed by combining providers and payers. The systems, brought together, to address population and information requirements will be both unique and daunting. Regulation can only occur in outcomes reporting, not at any detailed level that prescribes solutions.

As outlined in the NPRM, the Shared Savings Program is a key reform initiative at the center of CMS' vision for a 21st century Medicare delivery system. As part of that system, healthcare CIOs are ready to implement the technology and information exchange that will enable the tenets of better care for individuals; better health for populations; and lower growth in expenditures to become a reality. By balancing MU and ACO objectives; strengthening the role of data sharing and incentivizing better performance, we are confident that we can achieve these goals together.

We hope these comments are helpful. If you have any questions about our comments or need more information, please contact Sharon Canner at scanner@cio-chime.org.

Sincerely,



Richard A. Correll, President & CEO
CHIME

Dr. Lynn Vogel
Chair, CHIME Board of Trustees
Vice President & Chief Information Officer,
The University of Texas M. D. Anderson
Cancer Center

College of Healthcare Information Management Executives
4300 Wilson Blvd., Suite 250 · Arlington, VA 22203
Phone: (734) 665-0000 · Fax: (734) 665-4922 · staff@cio-chime.org · www.cio-chime.org