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VIA ELECTRONIC SUBMISSION

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Room 445-G
Washington, DC 20201

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RE: Request for Information - Advancing Interoperability and Health Information Exchange, CMS-0038-NC

Dear Ms. Tavenner & Dr. Mostashari:

The Long-Term and Post-Acute Care (LTPAC) Health IT Collaborative is a group of associations that work together to achieve their common interests and vision for their patients, employees and providers. The Collaborative includes representatives from Leading Age, the National Association for Home Care and Hospice, the American Health Care Association, the American Medical Director Association, the American Health Information Management Association, the American Society for Consultant Pharmacists, National Association for the Support of LTC, the American Association of Nurse Assessment Coordination, and The Commonwealth Fund. These comments reflect the insights of collaborative members.

The LTPAC vision encompasses a broad range of providers: home and community-based services; nursing homes; assisted living; long-term acute care hospitals; rehabilitation and post-acute care facilities; PACE programs; hospice; chronic disease and co-morbidity management; medication therapy management and senior pharmacists; wellness providers; and others.

Providers in the LTPAC sector concentrate on coordination of supportive services and care, restoring and maintaining health, wellness and functional abilities, and a particular, almost programmatic, focus on the particular needs and goals of each of its consumers and their families. This focus demands an application of health IT towards shared care, transitions of care, and person-centered longitudinal health and wellness records to ensure

a person receives affordable, quality and coordinated care when they need it, where they need it.

We are pleased that this RFI is looking to build on current laws and regulation, and encourage the identification of areas of success. We also encourage addressing the barriers to EHR adoption and Health Information Exchange (cost, complexity and need for standards to help manage both).

On behalf of our associations and their members, we are offering below comments on the Request for Information: “Advancing Interoperability and Health Information Exchange.”

General Comments

Adoption and use of health information technology is essential for LTPAC providers. As with acute-care providers, there are increasing levels of adoption, use and of the information technology. Core information technology is in place to meet care, business and regulatory requirements. This technology is growing in sophistication, including the incorporation of standards to support information exchange and advanced features like clinical decision support systems. More providers are starting to use these systems better to improve the care they deliver and care coordination.

While many aspects of patient care are similar among all care settings, there are significant differences in the goals, services and resources of the different settings, incorporating different workflow and extending over different amounts of time – generally significantly longer time periods with LTPAC providers.

Core capabilities to support standards-based information exchange must be consistent across all settings, but other health IT capabilities, and the systems to support them, will vary by setting. We are very concerned that some hospital systems are requiring discharge-destination providers to use the acute-care hospital’s systems – systems that do not meet the needs of the LTPAC providers.

Some LTPAC HIT vendors have received ONC-ATCB modular certification as well as CCHIT Certification. With the 2014 Edition, we expect more vendors will certify to the core capabilities for information exchange. This will be a very valuable building block for enabling exchange without custom interfacing and one-off integrations.

HITECH and the efforts of the Office of the National Coordinator for Health IT have done much to establish standards and to create a critical mass of systems among the incentivized providers. The Affordable Care Act and other changes in payment, are putting in place the partnerships necessary to improve transitions of care. The two together will be driving increased information exchange among all providers.

We are encouraged by the strong support ONC has provided to S&I Framework Longitudinal Care Coordination (LCC) workgroup as well as the Federal Advisory

Committee on HIT Standards. This has been a very active, community-based effort that has succeeded because of ONC's efforts as a convener.

The HIE Challenge Grants have been well received and are creating examples of excellence for engaging the long-term and post-acute providers. We applaud the effort, encourage more LTPAC Challenge grants and ONC's encouragement of all state to intentionally engage LTPAC providers in their HIE activities.

Healthway – a national infrastructure for operationalizing the standards and certification criteria for the exchange of health information – appears to be reaching a critical mass. Healthway, more so than the state and local Health Information Exchange organizations, strictly requires adherence to national standards. As such, it offers a low-cost option for information exchange.

We are concerned about an unintended consequence of HITECH, the cost of health IT driven by increased demand for technology and for people with HIT skills. This is having a ripple effect among non-incentivized providers who also need this technology and the people to implement it. We are also concerned if ONC placed a tax and increased certification fees on LTPAC EHR vendors, who are generally smaller vendors. We believe that this may result in increasing the cost of implementing certified EHRs in LTPAC and may slow down HIT adoption by non-incentivized providers.

The Collaborative puts forward the need for standards-based, interoperable “care-valuable” assessments. These are assessments that are valuable to the delivery of care and the communication of that care to other providers. To support LTPAC's communication and e-measure reporting, both care documentation and mandated assessments should be e-enabled.

In looking forward, we must remember that the increased presence of health IT and the new payment models are only now establishing themselves. Other necessary activities, from the wide availability of health information exchange organizations to the development of new EHR-enabled Quality Measures (eQMs), are still in process.

We recommend a moratorium on further quality measures until the eQuality Measures are harmonized across the spectrum of care. Rather than overload the providers with new requirements, focus on new measures that build on the growing presence of electronic system and reward those adopting EHRs with simplified processes.

Uncertainty of payment rules and rates causes hesitation to proactively invest in technology. At a time when there are reductions in payments, any increase in payment to long-term and post-acute care providers who are electronic would help support the investments in technology.

Comments on Questions

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?

Policies that encourage coordination of care and cooperation among providers will also encourage exchange of health information. Policy levers might include payment for receiving information and then using it, perhaps through a reconciliation process or other activity that takes existing information and adds value. This could include medication orders, lab results, narrative notes, care plans and advance directives, all of which have high value as care continues across organizational boundaries.

There are payment options for physicians offering telemedicine services. When those services are provided to patients in post-acute and long-term care settings, there should be a corresponding payment to the facility where the patient is located, since they are bearing some of the costs of the two-way communication with the physician – infrastructure and ongoing costs that include on-site video, telecommunications and electronic records.

Shifting the current required assessments to more care-valuable treatment tools would align regulations with generation of information that could be sent to subsequent providers. The work to convert MDS and OASIS to a CCD demonstrates the potential for re-using information and also highlights some key limitations: the information does not represent changing patient condition well, does not have sufficient detail to describe the care provided in the prior setting or the plans for the next setting. Nonetheless, it is a useful starting point.

Payment for reporting of quality measures derived from point-of-care electronic documentation (eQMs) would support the infrastructure to collect and report this information. It would also further the exchange among providers by supporting adoption of more electronic data during the care process and available for exchange.

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?

Since the hospital readmission payment adjustments are already in place and affect all hospitals, this has resulted in many partnerships to address readmissions. The other programs, including bundled payments, ACOs, medical/health homes, are also driving partnerships. While these are more limited in scope today, they are expected to become very prevalent in the near future.

Medicare Advantage and other managed care plans that put providers at risk for the total cost of care, are increasingly using health information from all providers as a tool for managing care, outcomes and costs. At least one MA program requires participation in their HIE.

Meaningful Use Stage 2 capabilities and incentives are expected to drive exchange of health information beginning in 2014, although it will likely be several years before this is fully implemented.

We would like to see educational and support programs, such as the Regional Extension Centers (RECs), paid for by ONC with the objective of the hospital and physician understanding the information needs and care provided by LTPAC. We would also like to see RECs support LTPAC providers.

As the above programs are implemented, we would like CMS and ONC to study and report on which programs and in what ways successful outcomes have been obtained. For example, where unnecessary admissions have been reduced, what were the factors that resulted in the improved outcome and what technologies and other factors were important?

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?

Programs that encourage the coordination of care and management of outcomes all encourage exchange of information. Exchange builds community and community builds exchange. These two reinforce each other. They are in contrast to programs that pay for services in isolation.

Establishing trust in the information coming from other providers is essential. This is partly a matter of establishing relationships and gaining experience with the exchange of information. It also includes technology and standards to track the information

provenance as it moves from provider to provider and system to system. Knowing the source and the context in which information was first collected is important to any subsequent use of that information. The information technology must display this information in appropriate user-friendly, contextual and non-intrusive ways.

There are two prerequisites for trusted information exchange: (1) knowing the identity of the sender and receiver and (2) knowing the identity of the person to whom the information applies. Provider identity management is already getting attention (see Question #7). However, patient identity management continues to be problematic. Various demographic information (for example, address, date of birth, phone numbers, email addresses) and other identifiers (including health plan and drivers license numbers) can be helpful. There are attempts to establish a private, voluntary patient identifier. These have merit as intermediate steps. We encourage ONC to study and report out on best practices for linking patient information as individuals transition from care setting to care setting.

Information supplied during the referral process that precedes a transfer of care is very valuable. There are a variety of barriers to accessing this information prior to admission that range from establishing a pre-treatment relationship, the selection of the information made available by the discharging provider and payment for the infrastructure that facilitates the referral process. Clarification of the Stark/Anti-Kickback constraints/establishing safe-harbor on paying for the referral infrastructure could remove this concern as a barrier.

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?

There is an established pattern of information exchange, mostly through paper documents, as people transition from care setting to care setting. While this establishes a baseline, it also demonstrates the limitations of information exchange – what is sent is based on the sender's needs and perceptions that do not fully match the recipient's needs. The work of the IMPACT HIE Challenge Grant is defining few robust data sets built around the type of care transition, informed by the needs of the subsequent care provider.

Privacy and consent varies by state. There are many circumstances where patients and providers cross state lines. Policy, procedural and technical guidelines for information exchange is needed. While HIPAA creates a floor that protects patient information, this does not meet the needs of providers who are under restrictions that sometimes override the patient's ability to consent to electronic exchange (such as mental health information in Illinois) or limitations on providers to re-disclose information provided to them.

CMS has established regulations to protect the rights of residents in long-term care settings. These regulations can be in conflict with other regulations addressing exchange of patient information. They should be reviewed in the context of changing patient expectations that their information be shared to better communicate their goals and wishes for care, and to improve the care, the clinical outcomes and their experience.

ONC has supported work on technical approaches to manage granular consent and protection of subsets of patient information. This addresses the underlying technology, an important component for managing information to patient requests and state regulations. We would like to see EHR certification criteria based on this work.

Support for developing a national consensus on privacy and consent models and publication of guidelines for the protection of information would further help in this area.

There are two areas where quality measure development can help: (1) measures of care transitions and (2) setting-neutral measures applicable in a wide variety of care settings using consistent definitions.

Transitions for care are filled with opportunities for missed communication and resulting problems with care – ranging from incomplete and inaccurate medication lists to voluminous and poorly organized printouts that not easily used by the receiving provider. Quality measures that address the care transition itself would create a framework for providers to partner on improving the transition.

Setting-neutral measures would help providers demonstrate the quality of the care they provide and also their contribution to changes in patient condition over time. These measures would be helpful to local collaborations that span care settings. They would also be helpful to the broader policy discussion of the value of each care setting. The work of the NQF MAP initiative is largely focused on the use of existing measures. There is a need for new measures which address the wide range of settings.

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?

The Conditions of Participation were written with the assumption that medical records are paper-based. Clarification of what constitutes an acceptable electronic medical record would remove a barrier to adoption of electronic health records.

There is added complexity in the post-acute and long-term care settings where physicians are not present all the time. This requires nurses and other clinicians to take on more management of the care process with remote support from physicians. The interaction with physician systems, often developed as stand-alone applications, is an emerging area where standards would be helpful.

States can play a leading role in coordinating care for all citizens and especially for Medicaid recipients. Massachusetts Medicaid is taking a leading role in establishing the state health information exchange. They are also developing services specifically tuned to the needs of providers that do not have systems capable of standards-based exchange.

The ONC State HIE Challenge Grants are an example of HHS leadership in including post-acute, long-term care and behavioral health providers in exchange of health information. These demonstrations are just now creating real exchange. They will be examples to build on. We encourage further support for these and additional demonstration projects.

The Meaningful Use program is creating a critical mass of adoption among acute care providers (hospitals and ambulatory practices). Clear, consistent and stable standards will enable vendors for the post-acute and long-term care providers to embed these standards in their products. This will minimize the need for any custom work to connect providers, eliminating a cost and complexity barrier to information exchange. The current Stage 2 requirements include electronic exchange of information at transitions of care. We support this and look forward to Stage 3 further addressing the needs of post-acute and long-term care providers.

We encourage continued support for the S&I Framework Longitudinal Care Coordination (LCC) efforts. This work is resulting in updates to the Consolidated Clinical Document Architecture (C-CDA) that address the needs of post-acute and long-term care. Much of the existing C-CDA specifications address what has happened to the person, the facts about them. The LCC work includes the plan of what will be done. Creating multi-disciplinary, multi-setting care plans that can be sent with the patient goes a long way to moving “the patient story” from a static to a dynamic document. This will be a powerful addition to the C-CDA.

Acute care hospitals typically only have patients in their care for a few days. The post-acute and long-term care providers have patients for weeks and months. This shifts the emphasis in the care plans from initial management of an acute condition to the extended care needed for recovery and long-term management of chronic conditions. Shifting the limited focus from acute care to the broader needs for maintaining health is consistent with the shift to medical/health homes and many of the ACA reforms. We are evolving from an episodic focused healthcare system first to a predictive and then to a preventive healthcare system based on analytics and eDecision software. This vision of the future must be taken into consideration when developing policy and programs so long-term value in quality of care and quality of life are achieved at an affordable cost.

This is another area where the Regional Extension Centers could be helpful. However, they may need support in reaching out to long-term and post-acute providers.

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?

The QIOs already work with post-acute and long-term care providers. Extending support for them, along with the RECs, to work with the implementation of electronic exchange of information, would combine process and technology expertise and build on existing relationships.

The survey process for post-acute and long-term care would provide a consistent way to collect better information on the adoption and use of EHRs and HIEs by post-acute and long-term care providers would be helpful. Creating good surveys that accurately assess the presence and use of these technologies would resolve many of the questions raised in the opening sections of the RFI. Training would likely be needed on collecting the information. There is already a state survey training process that could be leveraged. This might also provide a support activity for the Regional Extension Centers. Clarifying ambiguous, outdated or contradictory references to the use of health information technology and EHRs across the Medicare program (e.g. Conditions of Participation, Program Integrity guidance, Intermediary payer policies) will help to support provider confident in their investment.

In Question #4, we address needs for Quality Measure development, the value of e-measures and the importance of measures that address transitions of care.

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?

There are already state requirements and processes for licensing providers and National Provider Identifiers that could be used as the basis for provider directories. Developing standards for interoperable provider directories would be an enabling step. This would also allow the provider directories to extend beyond those providers attesting to Meaningful Use. The provider directories could be operated by the state HIEs or by other state agencies. Standards, testing and certification would be an essential element to ensure interoperable provider directories.

There are already provider identifiers used for mandated reporting (such as MDS for nursing facilities, OASIS for home health agencies and IRF/PAI for inpatient rehab facilities). Consistent identifiers across these programs would better align the different

initiatives. Beyond identifiers, consistency of reporting formats and transport mechanisms would, in the long run, remove technical complexity and provide better economies of scale.

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

We encourage using the provisions of the Affordable Care Act that support innovation to explore payment and service delivery models for person centric longitudinal care across the spectrum of care. We support the development of ACOs that specifically include long-term and post-acute care providers and require interoperable HIE. Some portion of payments could be directed to the hardware, software and training costs for LTPAC providers who are using electronic health records and exchanging health information.

Pilot and demonstration programs through CMMI focusing on evaluating the cost-effectiveness of innovative care delivery models that

- a) are either led by or emphasize strong partnerships with LTPAC providers and
- b) incentivize and encourage the use of technology (telehealth, remote monitoring, medication management (including medication adherence), EHRs, health information exchange and Care Coordination Tools) to coordinate care across provider settings.

At a time when there are reductions in payments, any increase in payment to long-term and post-acute care providers who are electronic would help support the investments in technology.

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?

Post-acute and long-term care providers have a great potential for increased patient, family and caregiver engagement through the use of health information technology. The time spent with these care providers and the importance of addressing chronic needs and the transition home or to lower levels of care is an ideal situation for improved patient access and use.

There is already a strong emphasis on patient education and training in the LTPAC settings. Adding electronic infrastructure will be an evolutionary step as there is increased adoption of EHRs and HIE capabilities.

Initiatives such as Blue Button and Blue Button Plus provide a means for patients to access their health information. These capabilities also can support transmission of the information to a personal health record, record bank or directly to other providers. As with other health information, preserving provenance will be very important.

Permission to share data: in addition to HIPAA regulations there are state and other regulations concerning how permissions to share information are given – every time data was going to be shared instead of a broad permission. If this is a requirement then nursing facilities would require a full time employee to managed permissions.

Defining what and how information will be shared is important. As with other providers, there is a fear of making statements that will be misinterpreted or cause offense. Detailed and specific notes are important to good communication among providers. These can also be very helpful to the patient, family and caregivers. As with the experience of physicians sharing their notes, clinicians in other settings will need training and support as their notes become more accessible. Patient, families and caregivers will also need training in how to understand the notes.

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

Post-acute and long-term care providers rely on outside laboratories to perform some or all of their lab tests. These lab providers typically provide some form of on-line results reporting using a web viewer. As LTPAC settings acquire more sophisticated EHR technology capable of managing discrete lab results, there is value in orders and results in their EHR.

The LOINC standard is a key building block for interoperable lab orders and results. Clinical labs should be required to implement LOINC regardless of whether providers can send or receive lab information.

Beyond LIONC, the processes around lab orders and results should be further standardized. Initiatives such as ELINCS need to be supported. In order for exchange to become widespread, the core processes need to be standardized. Otherwise the added costs of the interfaces will continue to be a major barrier to electronic exchange of lab results.

Beyond use of outside laboratories, there is emerging technology for “labs in a box” or “Stat tests” that offer automation of the lab tests and electronic reporting of results on site. This can be as simple as smart glucometers that send glucose levels directly to an EHR. Standards for device connectivity to EHRs are also important. This is an area where the less regulated, more consumer directed self-monitoring of chronic conditions will provide low cost options. Creating a bridge from these technologies to the more regulated professional-grade capabilities will be necessary to take advantage of these advances.