

April 17, 2013

Marilyn Tavever
Acting Administrator
Department of Health and Human Services (HHS)
Centers for Medicare and Medicaid Services (CMS)
and
Farzad Mostashari, MD
National Coordinator
HHS Office of the National Coordinator for Health
Information Technology (ONC)
Attention: Interoperability RFI
Hubert H. Humphrey Building , Suite 729D
200 Independence Avenue, SW
Washington, DC 20201

RE: Interoperability RFI (CMS-0038-NC)

Dear Ms. Tavever and Dr. Mostashari:

On behalf of the more than 67,000 members of the American Health Information Management Association (AHIMA), I am please to submit our comments and recommendations related to the request for information on the “Advanced Interoperability and Health Information Exchange” as published in the March 7, 2013 *Federal Register* (78FR14793-97).

AHIMA is the not-for-profit healthcare association for health information management (HIM) professionals who have been educated and trained in all aspects associated with health information and who work in over 40 employments types associated with our nation’s healthcare industry.

AHIMA is pleased that your agency and office have taken this step to invite public comment on how you can affect healthcare information interoperability through your policies and practices. These objectives related to the goals of interoperability and health information exchange are of great importance to our members who generally serve as the data stewards or governors of health information in their organizations across all sectors of the industry including involvement in organized health information exchange (HIE). AHIMA is also deeply engaged with a number of standards development organizations (SDOs) working to permit the accurate collection, storage, transmission, and understanding of health information as it appropriately is conveyed and used for improved patient care and quality, secondary uses, such as public health and quality measurement, and improved efficiency. AHIMA is also working to engage consumers in the understanding and active use of their health information and access.

AHIMA members believe that these goals will not be achieved until all sectors of the industry are included and incentivized to provide health information for the continuity of care and the improvement in care delivery. We agree with the premise of your questions that our healthcare reimbursement systems, including those of Medicare and Medicaid must align our reimbursement approaches and requirements.

Unfortunately, the uses of electronic health records systems (EHRs) while significantly affected by any direction that CMS takes are also subject to the requirements of other federal and state agencies as well as private health plans and other payers. We believe it is incumbent upon HHS to work closely with all stakeholders moving forward so that we can develop a uniform approach to the uses of EHRs and the capabilities of HIE organizations (HIEOs). To this end AHIMA has often called for a single HHS approach and strategic plan (with industry input and consensus) as we establish requirements, conditions of participation, and so forth for providers and others impacted by these decisions. This coordination includes setting the timetables or schedules for implementation, conversion, and so forth, which can provide for a strategic implementation across the industry, and not raise some of the issues we have today. We see this RFI as indicating an agreement by CMS and ONC to move us in this direction and we welcome your leadership and hope you will recognize our intent to work with you whenever possible to achieve our mutual goals.

General Comments

Our specific responses to your RFI questions are below, but AHIMA also has some general comment brought on by this RFI.

HIT Policy and Standards Committees

With the passage of ARRA – HITECH, AHIMA saw the opportunity to address the US healthcare information systems, exchange, and use as finally being addressed. The healthcare industry has needed a policy council for decades to determine what is needed in the arena of health information management and technology and the strategy to get there. Such councils exist in most US industries, but given its size this has precluded the establishment within healthcare. Unfortunately, HHS, in part due to the aggressive timetable Congress set in HITECH has been forced to concentrate on the stages of healthcare technology adoption, and not had the luxury of looking at the much larger picture that must include the transformation of health delivery and reimbursement as well as technology, work flow and best practices, and the impact of reimbursement and financial and other incentives.

With the Congressional mandate, HHS should look for a way for the HIT Policy Committee with a expanded workgroup structure to further industry involvement. This would allow the Committee to start looking at the larger picture and engage the industry, not just ONC or CMS programs. Then, we believe, a greater industry consensus could be built around issues such as those addressed in this RFI. We must note that in making this recommendation we also believe that ONC has limited the active participation of professionals, including health information management in the work group process. While we appreciate all the opportunities to comment, there is little time to participate in the actual discussion that results in work group recommendations.

LTPAC and Continuity of Care Issues

AHIMA believes that it was unfortunate that Congress did not address long-term and post acute care providers in the ARRA-HITECH incentive program. It is clear that you agree as well and are trying to address both the movement of LTPAC to the use of EHRs as well as to improve the continuity of care. We hope that as we move forward strategies will be developed to consider and coordinate all aspects of care as well as work to accelerate those providers that have not had the resources or advantage of programs like Meaningful Use.

AHIMA has worked with various CMS programs for years, and we are well aware that these programs are often siloed and on different timetables. We have worked hard to convince the various program components of the need for consistent data, and complimentary data sets. We have seen this changing very slowly and hope that as CMS and ONC look to change, the various HHS units and programs will also become more consistent in their requirements and recognize the overall aspects of data integrity, consistency, and use beyond that of their own program. In the meantime, we also applaud the Agency's move to improve data and information with such efforts as the adoption, implementation, and use of ICD-10-CM and ICD-10-PCS, and we continue our willingness to ensure the success of these programs and improvements within the industry.

We realize this will be one of many requests for information and we appreciate your desire to understand and work with the industry. We look forward to participating in these endeavors and working with our member professionals to improve our healthcare systems. Thank you for your time and consideration of these general and specific comments and recommendations. If you should have further questions or need for input from AHIMA, please contact Dan Rode, AHIMA's Vice President for Advocacy & Policy at dan.rode@ahima.org or (202) 659-9440.

Sincerely,



Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA
Chief Executive Officer

cc: Kathleen A. Frawley, JD, MS, RHIA, FAHIMA
President/Chair

Dan Rode, MBA, CHPS, FHFMA
Vice President, Advocacy and Policy

Specific Responses Below

Question 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?

AHIMA Response

Some of the work being done now is headed in the right direction. There needs to be incentives for the standard but complete exchange of health information among all providers related to an individual's continuum of care and this must occur in such a way that it does not block an individual's access to care as well. In other words, health plans/payers need to recognize the value of complete accurate data as it is used to treat patients across the continuum.

Since there may be multiple health plans or payers (public and private) involved across the care spectrum for the same individual, there must be mutual incentives covering the full episode of care as well. This either has to be voluntary or somehow legislated. Similarly, there must be standardized data or information that allows these stakeholders to evaluate the quality and outcome of healthcare. This would include agreement in the quality measurement that must be generated by the various care givers for the various payers.

The exchange of information in and of itself is not a final answer if there is no interoperability and data continues to be looked at from only an administrative perspective. For a successful effort to provide high quality of care for the best outcome and potentially lower the cost of care, all the providers (and to some degree payers/health plans) have to provide and have access to data. At present the incentive is limited due to the competing coverage of a patient as well as the lack of interoperability.

While hospitals and certain practices have been given incentives under HITECH, these incentives potentially have not been given to the full individual's healthcare team. Since care continues across the spectrum of ambulatory, acute, and post acute or long term care there are also payment issues as the payer may change. This too must be addressed in some manner but may take legislative action that could prove difficult with a zero-based reimbursement system; the shifting of funding must be made into a win-win solution. Since the reimbursement system does not increase or decrease payment based on the exchange or continuum of care, the reimbursement system as it currently exists, also does not recognize that care was improved. Some of the information that is being identified or not identified for transfer from one provider to another is not reviewed in a standardized way, again somewhat due to the reimbursement system, and therefore it is not clear if we are exchanging data for patient care or if we are exchanging data for reimbursement.

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Question 2a
<i>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?</i>
AHIMA Response
<p>None of these payment programs apply to the full continuum of care for reasons discussed in Question 1. For instance, from a hospital perspective, they are in a catch 22 with readmissions. There are penalties with readmissions; so, do you keep the patient longer to try to keep the patient from coming back but incur a longer length of stay or do you send the patient along and potentially increase the cost of post-acute care and potentially more costs when they are returned to the hospital?</p> <p>There is great promise in some of the pilots and new programs but it is far too early and we are now only beginning to recognize the issues of information exchange and interoperability. Some of these programs do not go beyond the point to point exchange of information and so can expand an enterprise model of some type which does lower cost but also does not address the issue of sending or receiving needed information outside of the enterprise and potentially limits an individual's choice of access. There are mostly hospital generated payment models so the readmissions payment model does not apply to most. The same with the HIE, if there is no incentive, then why implement?</p> <p>As noted in our response to Question 1, there are a number of different entities that need to be connected in an exchange to transfer information. For instance, if a patient is leaving a hospital and going to a nursing home or to home health, the information is initiated by an acute care facility, but it may need to be shared across the continuum - sent not only to the long term care facility, but may also need to be sent to the primary care physician, the consulting physician and even to the patient. Too often we think of only one way communication and do not think of all the players that might impact a readmission. This can be resolved by a single enterprise record, but does not achieve interoperability outside.</p>

Question 2b
<i>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 cross settings of care and among organizations that are market competitors?</i>
AHIMA Response
<p>As noted, if we are to achieve good quality, lower cost care, information must be shared across the continuum. There is fear in some communities that data shared in a large provider enterprise, is not or potentially cannot be shared with outside providers. While HIEs are being built to share data, this has not gone far enough for real interoperability and improvement of care.</p> <p>As our members also discussed these issue with others in the field, it is clear that there are so many programs underway many practitioners really do not understand the goals and objectives of each and how they play into new payment systems. This is further complicated by the</p>

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continued discussion on physician reimbursement, ACA changes, and other actions that cloud some industry consensus on a direction that will make healthcare better for patients and practitioners alike.

Question 3a

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?

AHIMA Response

Most payment policies effectively silo care in order to give the provider some ability to control costs. Consequently, it is cheaper to establish an enterprise model which could lead to private HIE, but prevent exchange across competitors or geographic arenas. A private enterprise also allows for more interoperability since the enterprise owner has some control on vendors and system integration.

The ACO model may be a means to circumvent this barrier, but there are then greater costs to achieve interoperability and there is still the issue of exchange of information outside of the ACO. It remains to be seen if ACOs will migrate to enterprises especially if the lower reimbursement for health services proves more rapid than the incurring of costs to build the infrastructure necessary for care and information exchange.

In addition to the exchange of data, we must look at the transformation of providing for the care itself. The activity of a patient care coordinator that works in a medial home, ACO or just provides care coordination, is not being recognized and therefore there is a negative incentive to do this unless you are in an organization with a goal to lower cost or if you are in an ACO. Still there is the possibility of care outside the network, and as we have noted the incentives for coordination of care or information outside of one's own enterprise is not recognized for a payment.

This discussion usually takes place at the institutional level, it ignores the private practice which is not large enough to influence this process and may either go out of existence or be bought up by an institution. This then limits the practice's ability to exchange data uniformly with different entities. US healthcare policy for information exchange or payment must recognize all of these forces.

Question 3b

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?

AHIMA Response

HIPAA is being used as a barrier for follow up on the patient. Care settings are trying to contact other providers that are outside of the network to review outcomes and are being told that they cannot share this information stating this is not your patient anymore. How can you measure quality outcomes when you cannot get information on how the patient is progressing?

The importance of continuity of care and overall quality has to stretch across the episodes of care and across the networks. Policies and practices (incentives to share consistent data) must exist; otherwise HIPAA continues to be used as an excuse. Until there are standard EHRs and interoperability, the cost of exchanging information in situations where there is no financial incentive to do so raises the costs of entities who may want to share information but find it cost prohibitive to do so.

A clear cut definition of what information is needed to be exchanged from provider to provider does not exist since current standards and required data sets have not been expanded to meet the continuum of care, two-way exchange, and other siloed requirements. For example, there is a need to have a standard of what elements are needed between care settings. There is a beginning of a model - the CCR, though this is not currently enough to serve all settings.

There is also a need for health information management best practices to manage the exchange (flow, integrity, and confidentiality) of the data beyond just the standards involved.

Data standardization is missing through the continuum of the record. Currently there is a lot of redundancy, same information in different formats. Health information management (HIM) professionals are concerned that this is hindering the use of EHR and HIEs. There are also different models of HIEs that may lead to additional barriers (possibly extend the use of the blue button to all care settings).

The basic data elements that need to be shared can be identified based on setting. The data sets need to be based on continuity of care, not reimbursement programs as they are now. It is time for CMS to recognize that we need to capture the same data as it moves across the continuum of care, the data need to be in the same language with the same definitions. There needs to be work done to come up with the singular, interoperable amount of information that moves back and forth.

The standards are not all in place yet, but AHIMA is moving to work with the industry to identify and exchange that information that is meaningful for continuity of care. AHIMA recognizes that there is still a lot of work that needs to be done from an interoperable standpoint. Consistent data sets need to be developed that can be exchanged using standardized language and terms or classifications within those sets. This has been an issue for the last decade; let's use this discussion as the fulcrum to get past this barrier.

Question 3c

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?

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<p>AHIMA Response</p>
<p>The healthcare industry should be able to develop some standard of what information comes from one setting to another and how to also provide information to the patient gets. Data element standardization (what information needs to be exchanged and alignment between providers and vendors) needs to be developed. Each setting has its own way to capture and display information but the information and associated meta data can be standardized.</p> <p>There needs to be a core standard EHR approved for EHRs. Having private vs. public HIEs with different vendors will potentially make sharing information difficult if there are not standards of what to share by setting.</p> <p>The HIT Policy and Standards structure in partnership with government agencies like AHRQ and industry professionals and settings need to be engaged in these issues – this is a discussion well beyond Meaningful Use. While there is a loose goal of information integration, the means to achieve the sub-objectives and tactics has not been discussed across the different sectors of the industry for many reasons and fears.</p> <p>In addition there is still a great need to assist providers, intermediaries, and communities to afford and have the technical knowledge to be part of this exchange. There has been progress, but there is much more to do.</p>

<p>Question 4a</p>
<p><i>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?</i></p>
<p>AHIMA Responses</p>
<p>There needs to be incentives or funding. Expanding Meaningful Use is one option, but both payment (for recognized costs) and perhaps loans need to be considered as well. This is not a good time for such a discussion given the debt issues in Congress, so HHS needs to join with the industry to make such a case. There also needs to be strategy developed to expand into post acute and long term settings so it does not become the start and stop process seen between healthcare providers in some communities. If interoperability is to be achieved then let’s insure that systems are developed and implemented with this as an overarching goal rather than systems that lock the data inside an organization.</p>
<p>Question 4b</p>
<p><i>How should these programs and policies be developed and/or implemented to maximize the impact on care coordination and quality improvement?</i></p>

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<p>AHIMA Comments</p>
<p>These providers typically work with the most vulnerable population, which is also the population that costs the most. Having incentives or a means for these providers to get EHRs and exchange information will have a significant, positive impact on managing this population's healthcare.</p> <p>To this end, AHIMA recommends a pilot to show that this could result in a lower cost to the Medicare and Medicaid programs. This pilot may be a combination of safe harbors and incentives monies from the HITECH and incentive funds in the ACA since we are talking about a change in the culture and the delivery of healthcare when we talk about the way we exchange the information. We suggest a policy reform through Medicaid or payment reform that could promote the exchange of health information.</p> <p>Outside of large corporate PALTC facilities, there is the opportunity to implement standard EHRs and HIE in a much more coordinated and goal directed (strategic) approach. Again, we recognize that the funding for such a pilot is questionable, but there is also an opportunity to attempt payment pilots as well.</p> <p>We have not seen all the results from the Beacon Communities and hope that there may be some means of using those experiences to respond to this question as well. These are issues and policies that need community input and are not easily addressed at the federal or even the state level. However, it must be recognized that many communities do not have the funds or mechanisms support all the exchange needed.</p>

<p>Question 5</p>
<p><i>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?</i></p>
<p>AHIMA Comments</p>
<p>AHIMA recommends reviewing the Conditions of Participation (CoP) for the various care settings and the certifications by various organizations and begin to certify on the basis of the use of EHR and involvement in open exchange. We believe this will facilitate the enterprise issues that continue to be brought up as a barrier to open sharing. The current CoP does not reflect the issues of continuity of care or the use of the EHR and we recommend that the conditions of participation include the exchange of information and the participation in the continuity of care. ONC needs to look at the other regulations, especially for substance abuse/behavioral health at the federal level and state by state to determine how to make sharing of this information work across the continuum. AHIMA is seeing this discussion move forward in some states and this could be expanded nationally</p> <p>Finally, as note elsewhere in these responses, Medicare and Medicaid need to both recognize the cost of implementing EHRs and HIE and provide payment for the exchange of information</p>

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necessary to achieve two-way continuity of care. CMS and ONC also have to work to ensure the interoperability of exchanges information while provider must ensure privacy and security as well as accuracy (as noted above).

Question 6a

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?

AHIMA Response

CMS through the work of its sister HHS offices and agencies and work with the industry must determine what constitutes a standard electronic health record. For each site of service, what information, and what circumstances must be present so that the record can serve as the basis for clinical care decision making and provide information for other secondary purposes. This goes beyond just the harmonization of storage, transfer, and other interoperative standards including terminologies, classifications, and meta data. They have to be basic and required of all entities in a defined grouping or subset of grouping. Only then can conditions of participation be utilized.

Providers need innovative processes to capture the data needed to fulfill the purposes above. The processes themselves do not have to be the same, but there needs to be certain business rules or operating rules to allow some assurance that the process is accurately collecting the information that has been determined as needed. The standard EHR must meet the changing perspectives of quality measurement, reimbursement, research, and so forth, so as medical knowledge increases the requirements for data likewise change. These requirements must be shared across the industry especially by those needing the data for approved secondary purposes, and clinicians

All of this requires consistency and a public/private partnership that does not currently exist as well as time to tackle these issue effectively. The HIT Policy and Standards committees give the nation the opportunity to address these issues, but they must move beyond Meaningful Use and look at the policies needed so that providers in different settings can know and rely on electronic health records and the data they contain for quality care and decision making, patient safety, and other agreed upon secondary uses. Likewise there must be public/private agreement on standards, standards governance, operating rules and so forth. All stakeholders need some consensus, or we will continue to build systems and silos to meet individual demand and follow the dollar, we have limited alignment for quality, payment, standards governance, etc. and this task has to be undertaken.

As we have indicated elsewhere, if we want a standardized uniform EHR we must be willing to pay for it; so as the industry addresses these issues, it must also look at how we will bring the many small providers forward to participate in networks using standard EHR systems.

We are seeing progress. For instance, the National Quality Forum is encouraging the

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Endorsement Committee to have measure developers align their measures across the continuum. One of the items NQF is working towards is aligning the value code sets for all settings for the care coordination. This standardization of measurements would facilitate the move of reimbursement from the basis of volume to the basis of quality. HHS through CMS and HHS can be a leader, but it will take an industry approach if this is to be resolved and we urge HHS to consider the promise of the HIT Policy and Standards committees and an expansion of industry involvement in its work groups.

Question 6b

How could requirements for acceptable quality that involve health information exchange be phased in overtime?

AHIMA Response

AHIMA has time and again suggested that quality measurement standards need to be uniform and consistent. This consistency begins by assuring that the data needed to generate a measurement is being collected in the standard EHR system, uses standard terminologies, meta data, and so forth, and is accepted (the measure) by all payers or other recipients of such data. Once this is in place, then such quality measures can be tested just as the industry is now testing ICD-10-CM transmissions.

Consider a phased approach similar to MU. The tiered approach over a number of years would give entities time to achieve implementation. In addition, there needs to be a certain amount of successful adoption before moving to the next tier. AHIMA recommends that CMS introduce mechanisms and measures and test the measure and mechanism themselves through pilots or demonstration projects, and apply across the continuum to test how they are working. There would be no penalties or rewards, just a testing process to be sure the process is working for entities across the continuum. The pilot or demonstration project would test how the EHR and HIEs can submit the data and ensure the information gets to the recipient, the provider, CMS or others, ensuring that the integrity of the data is intact. AHIMA recommends that CMS consider grants, demonstration projects and/or pilots for entities (must be across the continuum and payers) who are willing to be the pioneers to test. The government does need to be ready and should also participate in the testing.

Question 6c

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?

AHIMA Response

Is the compliance on the provider or the HIE, not sure? Are we looking at the integrity of the

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exchange? If so, then look at how we are testing for ICD-10. Give providers data sets to test the mechanism through the quality measure application to be pulled from the EHR and sent to the HIE to CMS and ensure the data integrity has been maintained. As a provider we would want reassurance that the integrity of the data has not been changed. Any items that involves payment and reimbursement needs to be assessed. A workforce that can assess and enforce will develop as the industry moves towards testing and on-going auditing of systems. We believe that just as HIM coding professionals are developing testing scenarios for tests, they can similarly do so for quality. Likewise, clinical information experts can audit systems to assure data integrity and the ability of the EHR system(s) to produce the necessary information needed and expected.

There are concerns that the current HIEs are editable by other providers. There are examples of where information in the HIE are edited and the information has been changed. There needs to be assurance of integrity as well as appropriate policies and procedures in place to enforce and ensure the integrity of the data being shared through the HIE. Setting up “stations” to periodically and randomly test data coming in versus data going out could alleviate this problem.

Question 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?

AHIMA Response

Infrastructure for exchange could be established through funding incentives that would provide a robust network to the providers. There is a need to establish standards that the identity correlated and matched that would bring confidence in the provider community on the data being exchanged linking the right data to the right patient. We are currently working on a project to encourage Congress to eliminate the ban on investigating identifiers.

From discussion with members and colleagues in the field, we are concerned directories are not complete. Before any incentives are provided it must be ensured that the directories are set up to meet consistent content structure, security, and other requirements.. The health information service provider (HISP) needs processes as well. Currently there is not one complete provider directory that may be used showing that the provider is the provider the organization thinks it is sending information to and the certificate is up to date. If providers cross state lines, there needs to be a process to be able to identify and share information across states.

Next, outcome incentives should be included for avoidable costs, there needs to be a tracking mechanism, for example, recognizing when a duplicate test was ordered, as the information was available to the right person and the right time. Any incentive program should only begin after all the standard mechanisms that deal with attestation and query are in place before exchanging information unless proposing a direct exchange instead of a direct query from an HIE. This request seems to be asking to find one partner to exchange information directly rather than find

data via a query.

There are issues of full utilization of the EHRs, and the CCD cannot be used. For example, having a problem list completed consistently in all systems is not feasible to the operations of these facilities, but there can be common elements determined and added to exchange standards. Facilities are still relying on the discharge summary; meaningful use requires that a percentage of the problem list, but this is being fulfilled by adding only one or two diagnosis, not the full complement of diagnosis needed for continuity of care.

There are still issues concerning responsibility for the problem list, there is a variety of staff (nursing, coders, etc) inputting the problem list. All the allied health professionals depend on the problem list and depend on this to be accurate. There needs to be a standard as to who has the authority to input the information and that the information is complete, not just one or two diagnosis when the patient has multiple problems.

These are examples of problems that need to be resolved before incentives are instituted and we urge CMS and ONC not to move so quickly as to ignore these problems.

Question 8

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

AHIMA Response

There needs to be a way to establish models and run them through the system. Another alternative may be to pilot and pay providers to help test the system. Until the payment requirements are established, most providers are not in a position to just "play around" with their system to see it works. Information needs to be able to be exchanged across the continuum to test the systems. Real time testing cannot be done since we don't know the requirements for the new payment system. It will have to test using pilots. It is not quite clear yet how we are going to transmit "claims data" as defined (not what we are doing today) to CMS. It will have to be tested across various systems and various HIEs.

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Question 9a
<i>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?</i>
AHIMA Response
<p>AHIMA recommends incorporating the Blue Button Plus program to be integrated into all systems along with initiatives under the ACO programs. As discussed once tested this could become part of an organization's CoP.</p> <p>Long term and post acute care groups need to have incentives to join in a meaningful use type program including consumer engagement.</p> <p>Changes in the Conditions of Participation. At some point an accountable care organization that is beyond a single entity would need to be accountable for integrity of the data by demonstrating the integrity to ensure that all the information from the ACO is being treated and handled appropriately.</p> <p>Establish a LTPACs ONC/CMS program called State HIE Cooperative Agreement Program to come up with solutions for transitions of care in LTPACs that encourage innovations in HIE that can be leveraged in NwHIN network, this work should be expanded upon and moved out to the entire NwHIN. Another suggestion is paying providers (both sending and receiving provider) for the work that is done for transition of care) while at the same time working with these groups to lower the cost of providing this information. In a number of states the reimbursement for such information does not cover the cost.</p> <p>There might also be a mean of lowering a Medicare patient's deductible or co-insurance when the individual can demonstrate their use of such information. We do not have an idea of how this could be done, but we are working with consumer groups on similar issues.</p>

Question 9b
<i>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?</i>
AHIMA Response
<p>AHIMA recommends CMS create an education program for their beneficiaries. Not only may there be reluctance for use of technology (both technology issues as well as anxiety for sending information electronically).</p> <p>CMS might look at innovation to assist low income individuals with phone apps or portals that can be downloaded on computers at a library, or other locations that might partner with CMS for such a project (e.g. AARP). It will be some time before all providers will be capable of providing</p>

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portals or similar access methodology. AHIMA suggests that as this occurs, access mechanism can be added to both ONC tool kits as well as eventually required in the CoP.

AHIMA also suggests using RECs, or similar organizations to implement and educate on portals and how to use them. RECs were able to achieve and surpass goals and this would potentially be a good use of their programs. RECs could also work with small providers to give them the means to have a Blue Button-type portal for Medicare beneficiaries.

Question 9c

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

AHIMA Response

The first opportunity is to finish the CLIA changes that give the labs the ability to release the lab information from the lab directly to the patient. In addition, there needs to be a standard terminology to convert the information for patients to clearly understand results. There needs to be a standardized scale to interpret the lab result. If a lab is abnormal, there needs to be a mechanism to automatically refer the patient back to their provider.

Other Recommendation s

AHIMA continues to see the need to harmonizing all of the consent requirements for HIEs (HIPAA, state laws, etc). AHIMA recommends that HIPAA consents for treatment, payment and operations be the standard all states follow. AHIMA recommends requiring consents be signed at the time of signing up for coverage for Medicare/Medicaid. If laws are harmonized to HIPAA, consents may only be needed for queries only. In addition, we need to standardize opt in/opt out models. Having various models across states will hinder the exchange. Once this is standardized, as more technology becomes available the consent directives could be updated accordingly.

ONC should be charged with providing education and technology to groups like the National Governors' Conference, National Association of Medicaid Directors, the National Association of State Legislators, and similar organizations. AHIMA also recommends education to patient right groups. If more information is available at the state level, we could work towards harmonization. Information needs to be pushed out rather than just having it on a webpage. AHIMA is working with its component state associations on a variety of projects and with the right materials can work with ONC and the state associations to achieve harmony and consistency.

As these changes occur, it is important that CMS reach out to beneficiaries and educate them on these changes. Again this is a program that AHIMA and similar groups could assist in.

Elderly parents often live on their own, and often do not live in same city/state as their children. Children of the elderly want proxy rights to the HIE to gain access to the parents' HIE. This would allow children of the elderly to monitor their parents' compliance with medication and treatment plans. This access would be view only. CMS should orchestrate this through one of their programs taking care to get the approval of the parent/patient before allowing such access.