April 22, 2013

Marilyn Tavenner, R.N.
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

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U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: Request for Information on Advancing Interoperability and Health Information Exchange [CMS–0038–NC]

Dear Madam Administrator and Dr. Mostashari:

In anticipation of the formation of the CommonWell Health Alliance™ ("Alliance"), we are pleased to submit comments to the Centers for Medicare and Medicaid Services ("CMS") and the Office of the National Coordinator for Health Information Technology ("ONC") on the request for information on advancing interoperability and health information exchange.

The Alliance is a collaborative effort between health information technology (IT) suppliers focused on achieving data liquidity between systems. The Alliance plans to be an independent not-for-profit trade association that will support universal access to health data through seamless interoperability. The Alliance will create and promote standards and policies to support a supplier-neutral platform to break down the barriers that currently prevent care providers from effectively sharing health data.

The Alliance plans to leverage existing standards and supplement only where needed to move forward the common good of scalable interoperability. The Alliance is taking a similar approach to the ONC Direct Project, as it was conceived on the heels of the work our founding members completed in that regard. The purpose of the Alliance will be to certify health IT services and standards that support its vision and mission. Initially, we will seek to certify core interoperability services and standards for health IT vendors that can be embedded within their own software to solve many of the challenges associated with interoperability.
CommonWell Health Alliance will define and promote the following core services and standards as early core components of the national infrastructure:

- **Patient Linking and Matching.** Provide a way for health IT suppliers to match patients with their health care records as they transition through care facilities in a seamless, industry-wide data environment.

- **Patient Access and Consent Management.** Foster a HIPAA-compliant and patient-controlled means to simplify management of data sharing consents and authorizations.

- **Link records across care locations.** Help providers link records to access a history of patient care encounters and patient data across multiple providers and episodes of care.

The Alliance is currently developing pilot programs to test initial core services, and we anticipate the ability to certify such services to vendors within 12-18 months. As the Alliance advances interoperability, its members will be expected to continue our work with the ONC to ensure our results are coordinated with ONC’s efforts to promote the interoperable use of health IT.

The members of the Alliance support the beliefs that patients’ data should be available to patients and their providers without regard to where or when care occurs, that providers should be able to access this data via their native health IT products, and that this ability should be available at a reasonable cost to the provider. The result will be data that is available for use at the patient’s direction by a broad range of providers, as well as by patients and their caregivers.

We appreciate the opportunity to provide comments.

### III. Questions for Public Comment

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?**

   The Institute for Healthcare Improvement (IHI) coined the term “triple aim,” which requires interoperable health IT and access to patient health information to improve care delivery. Health information exchange is one of the key enablers for the “triple aim” of better care, better population health, and reduced cost of health care. It is critical to the implementation of health care reform, improving quality, reducing costs, enabling regulatory compliance and ensuring better access to health care for millions of people. We recommend that CMS continue to adopt payment policies designed to reward the “triple aim.”

   As health care providers are asked to bear more of the risk associated with patient care, the need for truly coordinated care has grown. In an industry with multiple standards and hundreds of platforms, no single supplier can solve the problem of interoperability. By collaborating to create an open forum for secure patient data exchange, we can help remove the barriers to data access and move toward competition based on application competencies.

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?

We recommend that quality measurement be aligned across the Meaningful Use, Medicare Shared Savings (MSSP), Pioneer Accountable Care Organization (ACO), bundled payment and patient-centered medical home (PCMH) programs, especially when the same elements are measured. This alignment will enable health care organizations to focus more on quality delivery and less on quality reporting mechanisms.

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?

We encourage CMS and ONC to increase the alignment between payment and quality. As health care reimbursement models change, hospitals and health systems are also more accountable for quality outcomes and are taking on more of the financial risk associated with caring for a patient. To support both quality outcomes and financial stability, providers will need to coordinate care across all settings of care, without being limited by where, when and by whom a patient was last seen, or by the underlying electronic health record (EHR).

Health information exchanges (HIEs) provide deep connectivity in support of a health system’s or region’s needs to achieve population health, improved transitions of care, better care management, and increased health care efficiency. The Alliance will help HIEs by creating a common platform of broader, scalable interoperability for linking and matching, consent, and secure data access, but will not be a repository of data.

The U.S. health care system of the future will operate with health IT enabling a wide range of activities that will be expected to deliver better care at lower cost. Health IT vendors need to standardize the basics of interoperability in order to compete to help the care delivery system produce these expected outcomes. Government leaders have encouraged the health IT vendor community to solve the problem of interoperability. Vendor participation in the Alliance will support the goal to allow providers and patients to share information without regard for provider, time or place. Interoperability will improve care coordination and help providers to better engage patients in their own health care.

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?
CMS should align requirements for long-term and post-acute care providers with those for providers currently eligible for Meaningful Use incentives. CMS and ONC may want to consider voluntary long-term and alternate site EHR certification and potential incentive opportunities for these providers, including demonstration pilots. Health IT with appropriate interoperability capabilities ensures physician access to critical patient data without the constraint of the vendor system they use or cost-prohibitive investments to develop their own interoperability.

The ability to coordinate care in a cost effective manner is becoming increasingly important as reimbursement models and concepts such as risk sharing affect physician practices. For example, primary care providers who implement a patient-centered medical home model of care need a clear and complete understanding of the patient’s care to ensure care coordination and quality outcomes. Additionally, community providers will need to work closely with the hospitals they are associated with to manage readmissions and successful reimbursement bundling.

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?

CMS and ONC could promote appropriate HIE with consistent privacy rules across state lines. Variation in state privacy laws, including federal laws applicable to behavioral health, add greater complexity to the challenges of interoperability. Uniform privacy regulations would encourage providers and organizations to engage more readily in exchange.

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?

Alignment of CMS and ONC quality programs across all care settings would create consistent care coordination objectives and activities and minimize the need for additional regulatory requirements. We recommend that any further regulation avoid participation requirements, and rather focus on allowing the industry to determine the best way to achieve outcomes using HIE. We recommend that CMS and ONC encourage flexibility in approaches to allow for the emergence and continued development of innovative approaches like the Alliance.

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?

CommonWell Health Alliance comments to CMS and ONC on Advancing Interoperability and Health Information Exchange
We recommend that CMS convene all stakeholders to further explore this idea as well as other potential solutions to enable exchange among participating Eligible Professionals.

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?**

We encourage CMS to continue to adopt payment policies that focus on the “triple aim” of improving patient experience and population health and reducing the cost of health care. Rewarding continuous care and quality outcomes across all settings of care will accelerate the adoption of HIE.

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 programs to maximize beneficiary access to their health information and engagement in their care?**

The Meaningful Use program and various emerging delivery and payment reform models require providers to encourage active patient engagement, and we expect that effort to advance. We also recognize the work completed by the federal government’s health IT initiative and the Blue Button campaign, which has encouraged data holders and non-data holders alike to pledge to support the interoperability of health information. The announcement of the planned formation of the CommonWell Health Alliance is, in some respects, a response to that call, and we in the health IT industry are leading efforts to make health care data interoperable for the good of all.

The individual members that form the Alliance will have together pioneered patient-physician secure messaging, downloadable access to health records via the Blue Button and Blue Button+, and other innovative ways for patients to receive their own health data. The Alliance’s vision and mission reflects a belief that a highly functional and innovative health care system provides both patient-direct access and provider-to-provider access to EHRs. The Alliance will help foster a HIPAA-compliant, patient-controlled means to simplify the management of consents and authorizations for data sharing.

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

In 2011, CMS published a proposed rule on the “CLIA Program and HIPAA Privacy Rule; Patients’ Access to Test Reports” to amend the patient privacy provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and expand the patient’s right to access health records through enabling direct patient access to test results directly from laboratories. The preamble of the proposed rule explained that providing direct patient access to lab results would support our national commitments and goals regarding the widespread adoption of EHRs, robust health information exchange, and greater patient engagement in health care. We support the activities of CMS to finalize this rule.
Conclusion
The vision and mission of the CommonWell Health Alliance supports the efforts by CMS and ONC to advance interoperability and the exchange of health information. The Alliance members are committed to developing, deploying and promoting interoperability for the common good. Some or all of the Alliance members will also submit individual comments; however, the comments contained in this letter reflect our shared commitment to advance and achieve the broad goal of interoperability and information liquidity in health care.

The founding members,

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