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2
3 Donald Berwick, M.D.
4 Administrator
5 Centers for Medicare and Medicaid Services
6 U.S. Department of Health and Human Services
7 7500 Security Boulevard
8 Baltimore, MD 21244

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11 Dear Dr. Berwick:

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13 On behalf of the Board of Directors and members of HIMSS, we are pleased to submit written comments
14 to the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS)
15 regarding the [Notice of Proposed Rulemaking](#) (NPRM) published in the Federal Register on April 7,
16 2011, entitled, "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations"
17 [CMS-1345-P, April 7, 2011]. HIMSS appreciates the opportunity to leverage our members' expertise in
18 commenting on the Medicare Shared Savings Program NPRM.

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20 As you know, HIMSS is a cause-based, not-for-profit organization exclusively focused on providing
21 global leadership for the optimal use of information technology (IT) and management systems for the
22 betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have offices in
23 Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the United States.
24 HIMSS represents more than 37,000 individual members, of which two-thirds work in healthcare
25 provider, governmental and not-for-profit organizations. HIMSS also includes over 500 corporate
26 members and more than 125 not-for-profit organizations that share our mission of transforming healthcare
27 through the effective use of information technology and management systems. HIMSS frames and leads
28 healthcare practices and public policy through its content expertise, professional development, and
29 research initiatives designed to promote information and management systems contributions to improving
30 the quality, safety, access, and cost-effectiveness of patient care.

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32 Given the subject matter expertise of our membership, HIMSS is focusing our response on the following
33 five areas:

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- 35 • Eligibility and Governance
- 36 • Establishing the 3-year agreement with the Secretary
- 37 • Assignment of Medicare Fee-For Service Beneficiaries
- 38 • Quality Reporting and Other Reporting Requirements
- 39 • Shared Savings Determination

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40 **II. B. Eligibility and Governance**

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42 **2. LEGAL STRUCTURE AND GOVERNANCE**

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44 **a. LEGAL ENTITY**

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45 The NPRM solicits comments on the proposal to require the creation of a legal structure and seeks input
46 on other suitable legal structure requirements that should be added, including whether a requirement to
47 create a separate legal entity would create disincentives to forming an ACO. Observing that innovation



48 can be derived from various forms of governance and entities, HIMSS encourages flexibility in defining
49 “who” may be an ACO.

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51 In addition, HIMSS suggests that the government consider provider and facility concerns about data
52 ownership and liability associated with establishing and managing ACOs. For example, clarifying the
53 provider-patient relationship that is created by “looking at the data”, and how an “ownership interest”
54 stake will need to be defined between all the participating members in the ACO.

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56 To help address this issue, HIMSS suggests that legal implications, lessons learned, and practices that are
57 developing in the Health Information Exchange (HIE) community may be helpful to CMS. HIEs have
58 had to address provider concerns about reviewing health information of a person who is not his/her
59 patient, as well as whether there is any liability or obligation to 'provide care' for that patient.

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61 **5. AGREEMENT REQUIREMENT**

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63 HIMSS concurs with the CMS proposal to require a three-year partnership agreement between CMS and
64 the ACO.

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66 In addition, although HIMSS understands the need to create a disincentive on early termination of the
67 participation agreement, we are concerned that the proposed disincentive may actually be a deterrent to
68 those considering forming an ACO under this program. Using data from the Government Accountability
69 Office (GAO) on the estimated total ACO startup investment and first year operating expenses for the
70 anticipated number of participating ACOs, first-year investment averages \$1.8 million per startup.

71 Moreover, a recent analysis by the [American Hospital Association](#) estimated \$11.6 to \$26.1 million per
72 organization for investments required to implement and sustain the elements necessary for ACO success.

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74 Given the potential for high initial costs, some of which would likely be for necessary health IT
75 infrastructure and related resources, the proposal to retain the 25% shared savings hold-back if the ACO
76 terminates its agreement with CMS prior to the completion of the three years may prove to be an
77 untenable risk when deciding to make the high cost investments necessary to create an ACO under this
78 program. HIMSS understands that a hold-back is an important and potentially necessary to encourage
79 ACOs to complete the full agreement period. The challenge becomes finding the appropriate balance
80 between creating a disincentive for early termination, and creating the unintended disincentive to initial
81 participation. HIMSS suggests CMS may want to consider a more appropriate hold-back of 7.5% - 10%.

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83 **9. PROCESS TO PROMOTE EVIDENCE-BASED MEDICINE, PATIENT ENGAGEMENT, 84 REPORTING, AND COORDINATION**

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86 The statutory language establishing the Medicare Shared Savings ACO program stipulates that there are a
87 number of requirements that ACOs must satisfy in order to be eligible to participate in this
88 program. Several of these standards address how patient care is provided by the ACO, with a focus on
89 processes and methods to: (1) Promote higher quality of care; (2) better coordinate care; and (3) meet the
90 needs and concerns of patients and their families, including effectively engaging patients and their
91 families in medical decision-making. The law requires an ACO to “define processes to promote
92 evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate
93 care, such as through the use of telehealth, remote patient monitoring, and other such enabling
94 technologies.”

94



95 HIMSS applauds the recognition of the important role of health IT in the use of evidence-based medicine
96 and the potential to coordinate care. As noted in [HIMSS Public Policy Principle 1.10](#), HIMSS calls for
97 federal programs to incentivize and make available care coordination activities among healthcare
98 providers that serve those patients whose care is the most costly, such as patients suffering from more
99 than one chronic condition, are located in remote locations, receive care from multiple providers, or
100 require long-term care services, and those residing in medically underserved and health professional
101 shortage areas. Care coordination activities should utilize health IT, especially telehealth, to promote best
102 practices and preventative care. As such, HIMSS supports the inclusion of these technologies in the
103 coordination plans to be set forth by the ACOs.

104
105 HIMSS sees a strong potential for health IT to engage the patient in their own care. As described in
106 the [HIMSS Public Policy Principle 7.3](#), HIMSS supports the use of health IT, portable technology, and
107 social media to facilitate appropriate and timely consumer awareness; to facilitate and aid decision-
108 making regarding privacy; increase patient/provider communications; reduce medical errors; increase
109 patient safety; manage advance directives; improve the transparency of price, cost and quality; foster
110 trustworthiness among stakeholders; and, positively impact the health and quality of life for all
111 individuals residing in the U.S.

112
113 HIMSS concurs with CMS’ desire to support and promote innovation through the marketplace in a non-
114 prescriptive manner, including when and how to use HIT. ACOs, whether under this program or as they
115 are being created in the private sector, could serve as a laboratory for innovation in areas such as
116 evidence-based care, patient engagement, and care coordination. However, CMS does run a risk of not
117 describing the program well enough, thus limiting an ACO’s access to full knowledge of best practices or
118 the latest models or data that would support meeting these three areas. HIMSS suggests that it would be
119 helpful for CMS to have an objective set of criteria and ongoing evaluations in the areas addressed in this
120 section of the NPRM in order to ensure that ACOs are creating and then executing their plans
121 appropriately. HIMSS is also cognizant that a variety of definitions exist for terms such as “patient
122 engagement,” “patient-centeredness,” and “evidence-based medicine”. HIMSS suggests CMS provide a
123 clear definition of these terms, as we believe it would be very useful to ACOs.

124
125 The NPRM addresses a mechanism to support patient connectivity (e.g. remote monitoring and
126 telehealth), but is silent on the roles and responsibilities of stakeholders in coordinating care across care
127 modalities. As a multi-stakeholder organization, HIMSS recognizes there is a role for others who have
128 relevant skills and experiences in supporting coordination of care, such as health plans, to work together.
129 HIMSS suggests that in creating guidance to ACOs, CMS should include guidance on potential
130 coordinating partners.

131
132 Given the main programs in place that seek to transform healthcare delivery in the U.S., we strongly
133 encourage the federal government to coordinate efforts within and across federal initiatives. The ACO
134 criteria should map to and align with other federal initiatives, including the National Health Care Strategy
135 and Plan, the Medicare and Medicaid EHRs Incentive Programs (Meaningful Use), and the forthcoming
136 National Prevention Plan. In this way, coordinating across value-based incentive programs leverages
137 existing efforts, efficiencies, and knowledgebase. HIMSS members believe this would help to maximize
138 innovation and efficiencies for all activities.

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144 **10. PATIENT CENTEREDNESS CRITERIA**

145 **c. EVALUATION OF POPULATION HEALTH NEEDS AND CONSIDERATION OF**
146 **DIVERSITY**

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148 The HITECH Act directs the National Coordinator for Health Information Technology to “assess and
149 publish the impact of health information technology in communities with health disparities and in areas
150 with a high proportion of individuals who are uninsured, underinsured, and medically underserved
151 (including urban and rural areas) and identify practices to increase the adoption of such technology by
152 health care providers in such communities, and the use of health information technology to reduce and
153 better manage chronic diseases.”

154
155 HIMSS applauds the efforts across all of the Department of Health and Human Services to consider
156 diversity. This includes the Office of the National Coordinator of Health Information Technology, and
157 this NPRM which requires ACOs to describe their process for evaluating the health needs of their
158 Medicare population with an eye toward caring for a diverse population.

159
160 HIMSS knows that patients and the healthcare providers who care for these populations deserve
161 comparable support for electronic health information technology unaffected by race, ethnicity, gender,
162 geography or health financing. We continue to support the promotion of health information and
163 management systems’ contributions to improving the quality, safety, access, and cost-effective care
164 across all settings and for all patient populations, including those in culturally diverse or in underserved
165 communities. Some examples of HIMSS and our members’ engagement toward these goals include the
166 activities of the [HIMSS Latino Initiative](#), the [HIMSS Diversity Business Roundtable](#), and our [HIMSS](#)
167 [Public Policy Principle 8.1](#), supporting grants and other incentives to establish Health IT Action Zones.
168 Such Zones must demonstrate effective practices for promoting the adoption of health IT by licensed
169 clinicians who provide care to patients in vulnerable populations, as well as by providers who care for
170 patients who are medically underserved, including in rural areas, and are impacted by health and/or digital
171 disparities.

172
173 HIMSS is mindful that our membership and others in the healthcare community are keenly aware of the
174 importance of accommodating access in the healthcare setting. We recognize that awareness on this issue
175 must continue to expand to the health IT components of care delivery, particularly as we move to engage
176 the patient as a healthcare consumer. Issues that will be important to address include patient health
177 literacy, physical and mental capability, culturally sensitive care, and patient education between provider
178 visits. One of the many benefits of health IT is that the cost of producing information in variable
179 languages and in a culturally appropriate manner is less than in the current paper environment. This
180 provides opportunities for variations of consistent messages through culturally-appropriate mechanisms.
181 Mechanisms to access patient healthcare literacy need to be incorporated in the provider workflow.

182
183 As has been previously noted, HIMSS concurs that a non-prescriptive approach supports
184 innovation; we suggest that it would be helpful for CMS to have an objective set of criteria in these areas.
185 An objective set of criteria from CMS will ensure ACOs have knowledge of existing healthcare
186 community innovations, thereby enabling ACOs to create and execute their plans effectively. As such,
187 ideas, like producing information in an understandable and easily-accessible form in a culturally-specific
188 manner at the patient’s level of healthcare literacy, should be considered in guidance from CMS.

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190 **12. PROGRAM INTEGRITY REQUIREMENTS**

191 **b. CONFLICTS WITH PROGRAM REQUIREMENTS**

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193 The NPRM proposes that all contracts or arrangements between or among the ACO, its ACO participants
194 and ACO providers/suppliers, and other entities furnishing services related to ACO activities must be in
195 compliance with the obligations under the 3-year agreement, including document retention and access
196 requirements. CMS also proposes other requirements around data generation, including quality data or
197 other information or data relied upon by CMS in determining the ACO’s eligibility for, and the amount
198 of, a shared savings payment or the amount owed by the ACO. IT infrastructure will be critical to
199 meeting these data collection, retention, and reporting requirements.

200
201 HIMSS suggests that an alignment of CMS and ACO IT initiatives would also facilitate clinical
202 documentation with coding, billing, and receipt of payment as a means to leverage efficiencies and
203 reducing the demands on infrastructure and human resources.

204
205 **C. Establishing the Three Year Agreement with the Secretary**

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207 **1. OPTIONS FOR START DATE OF THE PERFORMANCE YEAR**

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209 The NPRM solicits comment on any alternatives to a January 1, 2012 start date that would allow the
210 greatest number of qualified organizations to apply to participate in the first year of the program.

211
212 Given the complexity of the proposed rule, and the potential that the final rulemaking will not be
213 published until close to the January 1 potential start date, HIMSS cautions that a January 1, 2012 start
214 date may create undue burdens on organizations. We suggest a start date of July 1, 2012.

215
216 **2. TIMING AND PROCESS FOR EVALUATING SHARED SAVINGS**

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218 The rulemaking notes that determination of an ACO’s eligibility to receive a payment for shared savings
219 will be based upon an analysis of the claims submitted by providers and suppliers for services and
220 supplies furnished to beneficiaries assigned to the ACO. CMS also recognizes that there are inherent lags
221 between when a service is performed, when a claim is submitted for payment, and when payment is made
222 (“claims run-out period”). The NPRM proposes using a 6-month claims run-out to calculate the
223 benchmark and per capita expenditures for the performance year.

224
225 HIMSS is concerned that this would pose too great of a gap in time for an ACO to utilize payment to
226 support necessary health IT investment. We recommend a 3-month claims run-out period. If CMS uses a
227 six-month claim run out, we strongly urge CMS to expedite subsequent evaluation of ACO performance
228 and notification and payment of shared savings (penalties). And, we urge CMS to consider a program for
229 advance payment of anticipated shared savings, as has been proposed for comment recently by the
230 Innovation Center.

231
232 **6. Sharing Beneficiary-Identifiable Claims Data**

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234 HIMSS concurs with CMS’ statement that sharing beneficiary identifiable claims data with ACOs will
235 assist them in improving care for individuals, improving care for individuals, improving health of their
236 populations, and reducing the growth in expenditures for their assigned beneficiary populations. HIMSS
237 supports CMS’ intention to make available individual claims data for assigned beneficiaries for health
care operations purposes, namely quality improvement and reviewing the competence and qualifications



238 of providers. In addition, given that claims data often is the only source of information about a patient
239 across multiple providers, we encourage CMS to permit the use of claims data for purposes such as care
240 management. Limiting its use would undercut the ability of an ACO to reduce unnecessary tests, engage
241 patients in wellness and disease management programs and otherwise manage care. HIMSS believes
242 HIPAA regulations provide sufficient guidance in the use and protection of patient data.

243

244 **D. Assignment of Medicare Fee-For Service Beneficiaries**

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246 **3. PROSPECTIVE VS. RETROSPECTIVE BENEFICIARY ASSIGNMENT TO CALCULATE**
247 **ELIGIBILITY FOR SHARED SAVINGS**

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249 HIMSS members have expressed concern that the proposed retrospective beneficiary assignment will
250 create a challenge because providers will not know which patients are assigned to them until after the care
251 has been provided. HIMSS recommends taking a prospective beneficiary assignment approach. If this
252 approach proves unworkable, HIMSS urges CMS to at least include the process used in the Pioneer ACO
253 model.

254

255 Finally, HIMSS requests that CMS consider special provisions to address ACO management and
256 responsibility for Medicare beneficiaries assigned to an ACO based on the plurality of their care, but yet
257 may receive the majority of their care from outside the ACO structure. Such situations may exist because
258 of extensive travel from a home location and/or involve a seasonal residence in other cities, states, or
259 countries.

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261 **E. Quality Reporting and Other Reporting Requirements**

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263 **2. PROPOSED MEASURES TO ASSESS THE QUALITY OF CARE FURNISHED BY AN ACO**

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265 HIMSS is a member of the National Quality Forum (NQF) and a partner of the National Priorities
266 Partnership (NPP). HIMSS supports the NQF endorsement process and recognizes the Measurement
267 Application Partnership (MAP) to align the measurement requirements across multiple CMS programs.
268 Of the 65 proposed quality measures, we suggest that CMS reduce the number of required measures, and
269 align those selected with other CMS pay-for-performance and pay-for-reporting programs.

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271 **3. REQUIREMENTS FOR QUALITY MEASURES DATA SUBMISSION BY ACOs**

272

a. GENERAL

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274 HIMSS concurs with CMS that multiple approaches are needed to capture quality measures data and
275 other metrics that will be necessary to improve care delivery. We look forward to future rule-making
276 offering greater real-time data capture and transmission.

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b. Group Practice Reporting Option TOOL

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279 HIMSS suggests that CMS work as early as possible with EHR vendors, DIRECT HISPs and HIEs to
280 support efficient interfaces between EHRs, HIE, and the Group Practice Reporting Option (GPRO) tool.
281 Additionally, the Quality Data Model developed by NQF should be supported to standardize data
282 collection.

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284 Given the fact that the GPRO tool has been in use for some time, HIMSS suggests that it is a data
285 submission tool that should be evaluated for expansion beyond GPRO.



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5. INCORPORATION OF OTHER REPORTING REQUIREMENTS RELATED TO THE PHYSICIAN QUALITY REPORTING SYSTEM AND ELECTRONIC HEALTH RECORD TECHNOLOGY

Because of the early state of the meaningful use program and because of adoption of Stage 1 is not known yet, many HIMSS members have expressed concern that the threshold of 50% of participating providers need to be Meaningful Users may be too high. Some providers may not choose to participate in Meaningful Use or be eligible to participate in the Programs, but still may be able to demonstrate the requirements of meaningful use.

For those not participating in the EHR Incentive Programs, this alignment should not be a rate-limiting factor. The ACO Program should not serve as a means to increase rigor for other programs. Eligible Professionals (EPs) should be allowed to submit to the Physician Quality Reporting System (PQRS) without participating in ACOs.

We commend CMS for responding to market forces and innovatively providing new approaches such as the Pioneer Model.

7. ALIGNING ACO QUALITY MEASURES WITH OTHER LAWS AND REGULATIONS

As stated in our response to Section II.E.2, harmonization of the quality measures across different quality bodies should be a major priority, recognizing that alignment and harmonization do not mean equivalence, especially given that some programs may require different kinds of measures than others.. There is undue burden placed on providers today reporting on same/similar quality measures, but required in different formats or time sequencing.

F. Shared Savings Determination

7. TECHNICAL ADJUSTMENTS TO THE BENCHMARK IMPACT OF BONUS PAYMENTS AND PENALTIES ON THE CALCULATION OF THE BENCHMARK AND ACTUAL EXPENDITURES

The NPRM notes the various in-place Medicare bonus and penalty programs. The NPRM proposes that such programs and associated incentive payments would (for hospitals but not for Meaningful Use EPs) affect actual expenditures and the benchmark, and thus an ACO’s ability to realize savings. Consistent with statutory authority, the NPRM proposes to exclude Medicare expenditures or savings for incentive payments and penalties for value-based purchasing initiatives such as the PQRS, the e-Prescribing program, and the EHR incentives for eligible professionals under the HITECH Act from the computations of both benchmark and actual expenditures during the agreement period. Because the statute does not explicitly grant authority to exclude other payments – such as EHR incentive payments to hospitals, the Hospital Inpatient Value-Based Purchasing Program, and EHR incentive payments to critical access hospitals (CAHs) – these and others would be counted in both the computation of actual expenditures and benchmark expenditures for Part A and B costs.

HIMSS members believe that the same rationale given for excluding Meaningful Use EPs must also apply to Meaningful Use Eligible Hospitals (EHs). HIMSS concurs with the belief expressed in the NPRM that it is important to ensure that these various programs’ incentives are properly aligned so that their interactions support rather than impede each of the programs’ goals. Although the statute does not



335 explicitly exclude these and other payments from the baseline calculation, it does not prohibit exclusion.
336 As such, HIMSS recommends that CMS use its discretionary authority to apply the incentive payments to
337 EHs under the EHR Incentive Program, as well as other similar incentives payments not covered under
338 the statutory authority, from both the computation of actual expenditures and benchmark expenditures for
339 Part A and B costs.

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341 We look forward to continuing the dialogue between our members and the Department to ensure the
342 development of an interoperable healthcare system to support healthcare transformation in the U.S. If
343 you have any questions, please contact [Thomas M. Leary](#) via email or at 703.562.8814.

344
345
346 Thank you,
347

348
349 H. Stephen Lieber, CAE
350 President/CEO
351 HIMSS