



COGON

CONNECTED, VALUE-DRIVEN HEALTHCARE

March 11, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Frizzerra:

Cogon Systems, Inc. is pleased to submit written comments on the Department of Health and Human Services Notice of Proposed Rule Making (NPRM), entitled, *Medicare and Medicaid Programs; Electronic Health Record Incentive Program [CMS – 0033—P; RIN 0938 – AP78]* that was posted in the Federal Register on January 13, 2010.

Among other business activities Cogon facilitates health information exchange through its virtual health network (VHN) platform, whereby healthcare providers in distinct care settings have the ability to share clinical information via a secure access clinical portal. The goal of Cogon's VHN is to improve patient care. Cogon's VHN solution finds, compiles, and presents patient data to caregivers in a manner that facilitates clinical decision-making. Cogon is a technical partner in a ground-breaking effort to exchange health information between multiple, civilian provider organizations and military providers in Pensacola. The Pensacola Health Information Exchange (HIE) operates on a business utility model. Hospitals, nursing homes, physicians, and other health care providers pay an annual subscription fee or a pay-per-use fee for access to the HIE's data. This utility model provides a sustainable business model for operating the HIE, while limiting the financial risk to providers who need this vital information to support patient care.

At the heart of this system is flexibility. The exchange can work with several electronic record systems. The utility can connect operations within a single health system, for example, or connect multiple unrelated providers. Functions can occur before entering the exchange or within data warehouses at the exchange. The exchange can have additional applications or connect to additional applications. There are a wide range of services possible through the system including the exchange of data to enhance continuity of care, patient demographic and administrative information, diagnoses/problem lists, providers, allergies, medications, laboratory results, radiology results, previous procedures, clinical notes, and more.

Cogon supports incentives for adoption and use of electronic health record technology. Ultimately, however, such adoption and use must be based on sustainable business models that provide value and efficiency to the health care system in local circumstances and in the context of thousands of different types of practices and technologies.

The crux of our comments is to ensure that the final rules do not, to the extent feasible, limit appropriate means of accomplishing health care objectives. CMS rules should not favor specific types of technology, particular types of health information exchange, particular types of relationships among parties, or particular types of business models. The Notice of Proposed Rulemaking and the interim final rule for certified electronic health information at a first level appear consistent with our point of view. For example, we applaud the provisions in the interim final rule regarding using a modular approach to defining an electronic health record. We believe this reflects the reality that there are many systems that connect in many different ways.

On this same theme, we recommend that CMS clarify that non-certified technology may also be part of a system to accomplish objectives along with certified electronic health record technology. If CMS does not do this, the agency will undermine numerous legitimate systems and create an overwhelming new certification bureaucracy and burden for providers and exchanges.

Even with these clarifications, we would ask CMS to be careful that the practical burdens of the certification and attestation system not create the problems we describe above. We believe the world of exchange is in the process of sorting out innovations and approaches. We want to make sure that the utility business model is one of the tools in the tool kit that is allowed to compete with other approaches on basic grounds such as true return on investment and ease of operation. The best test is financial and health care reality not the construction of a set of regulatory requirements.

The regulations have several confusing components. For example, we are not sure how providers can easily attest to the capability to exchange with hundred of public health agencies. Those agencies themselves do not have consistent portals.

We note that under section 495.8(a)(1)(i) and (b)(1)(i)), the proposed regulations require hospitals and eligible professionals to attest that during the EHR reporting period, the hospital or EP used certified EHR technology and specify the technology used. It would be helpful to allow for a good faith standard for this attestation and a clarification that the provider need only provide a general description of the technology used. Keep in mind that various elements of a health information system may be part of a continuous process of upgrade and improvement. Specific attestations, descriptions and certifications would either needlessly slow this process down or be routinely inaccurate.

Providers may not physically own elements of the system. There may be shared functions with other entities. Moreover, in our case, a web-service approach – which seems to be the dominant trend—will mean that technology use options are available to all who can access the web. That means some organizations will be very reliant on other organizations to maintain or use certified electronic health record technology. There is nothing wrong with this, but CMS must take care that the attestation process allows for a good faith understanding of what health information service providers may be using.

Under section 495.8 (a)(1)(ii) and (b)(1)(ii) of the proposed rule Hospitals and providers must also show that they satisfy each of the applicable objectives and associated measures under section 495.6. It is confusing to require satisfaction of the objectives. From all appearances it is only measurable to satisfy the measures. The measures may implicitly or explicitly refer to an objective, but the objectives are much broader and more ambiguous. We assume that CMS means that satisfying the associated measure is what is required to meet the incentives. If that is not the case, the rules have significant workability problems

We further recommend that CMS reduce the number of specific criteria that eligible providers must meet in the first two years of this program; reflect differences in what is meaningful across different practices, and also build in some flexibility for providers to select criteria that specifically fit their practice environment. We support the suggestions at the February 17, 2010 HIT policy committee to move away from an all or nothing approach to the objectives and measures.

Thank you for the opportunity to comment on these proposed regulations. As a general matter we continue to recommend that the market and actual providers and consumers of health information systems determine the most meaningful ways to use such systems. Over time, only sustainable business models that are not reliant on government funding will be successful.

Sincerely,

Huy B. Nguyen
CEO
Cogon Systems, Inc

Nandan Kenkeremath
Vice President, Strategy, Policy & Relations
Cogon Systems, Inc.