AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

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VIA ELECTRONIC MAIL

regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in Federally-Facilitated Exchanges and Health Care Providers

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to provide the following comments in response to the Center for Medicare and Medicaid Services (CMS)'s Interoperability and Patient Access proposed rule. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 85 hospitals and more than 300 other health facilities in 17 states.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographical locations, we strive to provide an objective and sound health policy voice that is relevant across state lines and sectors of care.

Below, please find AHPA's comments and recommendations on CMS' proposed interoperability rule. Specifically, we comment on the following issue areas:

- Conditions of Participation
- Digital Contact Information
- Information Blocking Attestation
- Application Programming Interface (API) Requirements and Timing
- Request for Information: Advancing Interoperability

Conditions of Participation

CMS proposes requiring providers to send electronic notifications through the Electronic Health Record (EHR) to other providers who have an "established care relationship with the patient relevant to his or her care." These notifications would need to happen at the time a patient is admitted, transferred or discharged from the hospital. The notifications, commonly called ADT notifications, would include the patient name, treating practitioner name, sending institution name, and, if not prohibited by other applicable law, the patient's diagnosis. In addition, CMS proposes requiring hospitals to demonstrate that the notification was:

a) transmitted at the time of the event;

b) for treatment, care coordination or quality improvement purposes;

c) sent to a provider with an established care relationship with the patient relevant to his or her care;

d) sent to whom the hospital has a "reasonable certainty" of receipt of notifications.

AHPA does *not* support this proposal because the lack of interoperability among EHRs may make it difficult for hospitals to have "reasonable certainty" of another provider's receipt of the information. Additionally, sending patient information to another provider may not always result in that provider being able to access the information, which defeats the policy's goal of improving care coordination. This is due to the lack of interoperability among different EHRs, including firewalls that may exist within another health care system. We believe that it is premature to adopt a Condition of Participation on the transfer and receipt of electronic patient notifications when interoperability issues that are outside of hospitals' control are still being resolved.

Rather than adding ADT notifications to the conditions of participation, **CMS should utilize other existing policy levers to promote interoperability and data exchange.** For example, CMS could work with the ONC to ensure that EHRs have the capability to collect the data elements needed to support ADT notifications, include standardized ADT data classes within the U.S. Core Data for Interoperability (USCDI) standards and consider incorporating ADT notifications into the Promoting Interoperability program as a high-priority health IT activity.

Digital Contact Information

CMS proposes to publicly report the names and National Provider Identifier numbers of providers who do not have digital contact information included in the National Plan and Provider Enumeration System (NPPES). The proposal aligns program requirements across Medicare Advantage organizations, Medicaid state agencies, Medicaid managed care plans, CHIP agencies and CHIP managed care entities.

AHPA supports the public reporting of providers without indexed digital contact information and believes it to be a good step toward promoting interoperability. Digital contact information, such as a Fast Healthcare Interoperability Resources (FHIR) server URL, is needed for the secure exchange of information between providers. We also commend the Trump Administration for proposing the second half of 2020 as the start date for this public reporting, as facilities may need to use the first half of the year to update and correct digital contact listings. **We ask that CMS provide a process for clinicians to review and appeal any incorrect web listings regarding digital contact information.**

Information Blocking Attestation

CMS proposes to publicly report certain data regarding providers' attestation statements, in which providers agree not to engage in the anticompetitive practice of information blocking. Physicians' responses to the information blocking attestation would be reported on Physician Compare; hospitals' responses would be posted on a CMS website.

AHPA commends the Administration for its efforts to reduce information blocking and promote data liquidity. Information blocking impedes hospitals' ability to provide high-quality, coordinated care through the exchange of Electronic Health Information (EHI). AHPA strongly believes that refusing access to patients' EHI should not be used to limit patient mobility between competitors.

API Requirements and Timing

CMS proposes to require that health plans implement, test and monitor openly-published APIs. The information included in the open API would include claims data (including cost), provider remittances, capitated provider encounters, cost-sharing data, clinical data, provider directories and formularies.

Health plans would have one business day to make data available through the API upon receipt of encounter data from providers.

AHPA shares CMS' goal of empowering patients to make informed care decisions but opposes the stringent timeframe requirements proposed. We are concerned that giving plans only one business day to publish may cause health plans to, in an effort to remain compliant, impose unrealistic or impossible turn-around times on providers. While AHPA believes that providers should be prompt in their submission of encounter data, we are concerned that a one-day timeline will increase the risk of data errors. Complex claims cases, such as those often seen in the emergency setting, often involve a wide range of care interventions and require more careful processing. **To ensure that patients receive accurate and complete data, we request that CMS increase the timeline for health plans to feed data into open APIs.** In addition, AHPA recommends aligning CMS' timeline for overall API deployment of July 1, 2020 with the proposed January 1, 2020 timeline in the ONC proposed rule. Incongruent timelines could cause interoperability problems between software or providers.

Request for Information: Advancing Interoperability

CMS requests comments on how it could leverage its program authority to improve patient identification and interoperability.

Patient Matching

One of the greatest interoperability barriers hospitals currently face is the inability to accurately match patients between health care systems and Health Information Networks. (HINs). To be able to coordinate care and share relevant clinical documentation, HINs must be confident that they are exchanging data about the same person. Current standards do not go far enough in enabling this type of matching. To address this issue, **AHPA recommends the use of a national patient index with national patient identifiers to facilitate patient matching and interoperability.** If a national index proves too difficult to achieve in the short term, we recommend requiring a common probabilistic matching algorithm to identify patient matching for HINs and providing guidance on thresholds for creating a positive match. This requirement would standardize the demographics that health care systems and vendors must capture for relevant matching criteria.

Behavioral Health Data Access

AHPA urges CMS to influence an amendment of the Federal substance abuse law's (42 U.S.C. § 290dd-2) regulations, known as 42 CFR Part 2. The lack of alignment between 42 CFR Part 2 and HIPAA presents a large barrier to interoperability throughout the care continuum. Although changes have been made, 42 CFR Part 2 remains a burden because the privacy protections travel with the information. This differs from HIPAA and other confidentiality laws that recognize that information recipients may not be subject to the same privacy restrictions as the entity that disclosed the information. Furthermore, the law is more restrictive than HIPAA and requires additional consent prior to the disclosure of substance use information. This additional restriction leaves providers with limited information and inhibits their ability to make the best possible decision about a patient's clinical care.

Conclusion

AHPA appreciates the opportunity to submit comments on the proposed rule and welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AdventHealth.com.

Sincerely,

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President
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