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Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Dear Administrator Verma:

On behalf of the Healthcare Information and Management Systems Society (HIMSS), we are pleased to provide written comments to the Notice of Proposed Rule Making (NPRM) regarding the 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 the Federally-Facilitated Exchanges and Health Care Providers (CMS-9115-P). We appreciate this opportunity to utilize our members' expertise in offering feedback on potential ways to improve access to, and the quality of, information that Americans need to make better-informed healthcare decisions, including data about health care prices and outcomes, while minimizing reporting burdens on affected plans, health care providers, or payers.

HIMSS is a global advisor and thought leader supporting the transformation of health through information and technology. As a mission-driven charitable organization, HIMSS offers a unique perspective with deep expertise in health innovation, public policy, workforce development, research, and analytics to advise global leaders, stakeholders, and influencers on best practices in health information and technology. Through our innovation companies, HIMSS delivers key insights, education, and engaging events to healthcare providers, governments, and market suppliers, ensuring they have the right information at the point of decision.

As an association, HIMSS encompasses more than 76,000 individual members and 660 corporate members. We collaborate with hundreds of providers, academic institutions, and health services organizations on strategic initiatives to advance the use of innovative information and technology. Together, we work to improve health, access, as well as the quality and cost-effectiveness of healthcare. Headquartered in Chicago, Illinois, HIMSS serves the global health information and technology communities with focused operations across North America, Europe, United Kingdom, the Middle East, and Asia Pacific.

As our healthcare system continues its shift toward value-based care, it is critical that patients remain at the center of their own healthcare care team, an objective that is accomplished by making sure they are well informed on all of their healthcare decisions. Critical to enabling an informed

patient is access to as much actionable information as possible, including data about healthcare prices and outcomes. In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) goes to great lengths to allow patients to control their own healthcare information and acquire knowledge. HIMSS supports CMS's focus in this rule on interoperability and patient access to data through enhanced use of technology such as application programming interfaces (APIs). HIMSS agrees with the CMS goals and general approach to advance interoperability and patient access. We also strongly support CMS's work with the private sector to advance these initiatives, including Health Level 7 (HL7®) and the Da Vinci project, a multi-stakeholder initiative to accelerate the adoption and use of the HL7 FHIR standard in the payer space.

APIs for Payers/Health Plans

HIMSS supports the CMS proposal to require Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and qualified health plans (QHPs) on the federally-facilitated exchanges (FFEs), to use open APIs. In addition, we support the use by reference of the Office of the National Coordinator for Health Information Technology (ONC) standards for such open APIs. Implementing this proposal would enable third-party software to access information only available within a beneficiary's current health plan. Making patient information more readily available will enable patients to better understand their healthcare cost, and offer provider organizations and researchers the opportunity to deliver very real value in efforts to foster better outcomes for patients and decrease unnecessary cost expenditures across our healthcare system.

From day one, it is critical that a consistent, standards-based approach be followed by payers and health plans, that requires concrete, detailed guidance from HHS. We strongly encourage CMS and ONC to provide specific guidance to health plans and payers that are expected to implement these new requirements, as this will ensure that the work done will yield consistent, actionable data and increase value-based care delivery opportunities, and not duplicate efforts of providers. Given the proposed requirement to include clinical data, we ask CMS to provide at least 18 months after publishing the final rule for this requirement to be mandated in order to allow those entities that do not normally manage clinical data, like private payers, the time to develop and make their APIs publicly available.

Hospital Conditions of Participation

HIMSS is supportive of the intent behind the proposal to revise the Conditions of Participation for Medicare and Medicaid participating hospitals to include a requirement for sending electronic notifications upon a patient's admission, discharge, and/or transfer (ADT) to another healthcare facility or provider. However, many stakeholders from across the community have raised objections about using the Conditions of Participation in this way. HIMSS supports the idea that increased data sharing (including ADT feeds) is a critical component of healthcare transformational efforts, but we do not want to use Conditions of Participation requirements as a vehicle to facilitate this exchange.

Instead, we encourage CMS to look at utilizing the Promoting Interoperability Program (PIP) for this purpose. There is certainly clinical benefit in the use of ADT feeds in care coordination, and many hospitals are already using ADT notifications in at least some capacity. The additional

burden from a PIP requirement would be minimal, and CMS could use this policy lever to promote the development of more advanced approaches toward these types of notifications.

Under PIP, HIMSS suggests expanding the electronic notification requirement to include the emergency department (ED) because of the clear value in the exchange of information related to ED visits. We also suggest that this requirement not only be limited to those organizations with an EHR implemented. Allowing organizations without an EHR to circumvent care coordination rules serves as a perverse incentive to avoid adoption of important technologies.

HIMSS wants to push our entire field forward and use all information and technology tools available to facilitate greater interoperability as well as support improved value and innovative care delivery. CMS should focus on implementing the other provisions in this regulation as well as support the work of ONC to implement the information blocking regulation—taken together, the regulations will have a significant impact on increasing data exchange, more than any benefit that would be gained from changing Conditions of Participation requirements.

In addition, before advancing any ADT requirements, CMS must ensure that the required functionality is available on the receiving end, as is not universally implemented today. In addition, CMS should consider using the Center for Medicare & Medicaid Innovation (the Innovation Center) to create a demonstration program that could help determine the most efficacious information to include in an ADT feed, and the most impactful care team members with whom to seek to share the information. HIMSS is concerned about adding any additional burden on a hospital or its staff in identifying the patient's care team, therefore a demonstration project would allow many issues and concerns to be addressed before a requirement is in place.

Finally, the creation of a directory through which providers can connect to each other in a consistent and cost-effective way will be fundamental to the success of this effort, as recognized in both the proposed rules from CMS and ONC. The technical ability to identify information about who you are expected to notify—the terminal address the notice needs to go to—is not in place at this point, and the development and dissemination of that directory must be completed before a requirement is in place. Even if providers have digital addresses—such as the National Plan and Provider Enumeration System (NPPES) requirements—patients most likely do not have this information, and it is not easily accessible.

Trusted Exchange Networks

The exchange of health information electronically requires a trusted framework that is able to verify a secure infrastructure as well as the identity of a patient. Trust networks are those in which plans and providers can share information freely no matter the health information sharing network with which they belong. However, as noted in the proposed rules, there are a limited number of networks today, and there is a need to expand and integrate more plans and providers into these networks. HIMSS offers its support to the idea that CMS programmatic payers should be able to participate in a trusted exchange network of their choosing, that would allow them access to other networks and lead to the nationwide exchange of data. We endeavor to create sharing between these networks that would allow data to flow securely and privately between plans and providers throughout our entire healthcare system.

While HIMSS agrees with the proposal that requires MA organizations, Medicaid managed care plans, CHIP managed care entities, and QHP issuers in the FFEs to participate in trust networks to

improve interoperability, we are concerned about the timeline for implementation of this proposed requirement. It has been noted that in some parts of the country trusted exchange networks do not exist where a health plan operates. Therefore, it will take some time for networks to be created in such areas. Additionally, with the April 19, 2019, release of Draft 2 of the Trusted Exchange Framework and Common Agreement (TEFCA), ONC outlines a common set of principles, terms, and conditions to support the development of a Common Agreement that would help enable nationwide exchange of electronic health information (EHI) across disparate health information networks (HINs).

The TEFCA is designed to scale EHI exchange nationwide and help ensure that HINs, health care providers, health plans, individuals, and other stakeholders have secure access to their electronic health information when and where it is needed. Given the long IT development timeline that is required, HIMSS recommends that CMS should not require the use of trust exchange networks for private payers until the structure and requirements around the TEFCA are more clearly defined and enacted.

Transparency Proposals

Within the proposed rule, CMS is looking to use transparency in hopes of pushing providers to advance interoperability and increase patient access. Electronic addresses allow providers to exchange data faster while improving interoperability and could eliminate the need for fax machines for the exchange of health information. A centralized directory of provider electronic addresses for data exchange would support the seamless flow of patient information as well as any needed provider-to-provider communication.

The 21st Century Cures Act required the Department of Health and Human Services (HHS) to create a provider digital contact information index, and as of June 2018, the National Plan and Provider Enumeration System (NPPES) has been updated to include one or more pieces of digital contact information that can be used to facilitate secure sharing of health information. HIMSS supports the CMS proposal to publicly report the names and National Provider Identifiers (NPIs) of those providers who have not added digital contact information to their entries in the NPPES system beginning in the second half of 2020, as we think this transparency initiative will push providers to take this critical step and help facilitate greater care coordination.

Any healthcare practice that unreasonably limits the availability, disclosure, and use of electronic health information undermines efforts to improve interoperability. For this reason, HIMSS offers its support of the proposal to make publicly available the names of those organizations or providers that submit a "no" response to any of the three attestation statements regarding the prevention of information blocking in PIP, as this transparency should help contribute to greater information sharing.

Request for Information on Advancing Interoperability across the Care Continuum

In its Request for Information (RFI) on Advancing Interoperability Across the Care Continuum, CMS outlines the lack of adoption/use of certified health information and technology among a number of other care settings, and we applaud CMS for trying to encourage the adoption and use of health information and technology in these settings. Increasing electronic data capture, applying the data to opportunities like clinical decision support and registry reporting, and improving care

coordination with other stakeholders will result in positive returns for patients, caregivers, health plans (including Medicare and Medicaid), and public health entities.

There are various technologies adopted and interoperability capabilities across these care settings and could lead to an inequitable distribution of both financial and workforce resources. As there are various exchanges of data currently happening (e.g. minimum data set, claims data, HL7 data feeds to pharmacies, etc.), CMS should look to augment the steps already taken by these organizations, and build on existing exchange modalities already happening and leverage/incorporate technologies that have already been adopted.

While the CMS Proposed Rule is oriented towards interoperability, it is first necessary to digitize the environments named in this RFI with modern, robust technologies. While stated adoption figures can make it appear that EHR use in those settings is reasonable, in reality, many systems in use are fairly simple versions of the software and are frequently incapable of connectivity to HIEs or support of APIs, as example. Moving those care settings forward so they are using updated health IT will need to be step one, and it is clear that some type of incentive will need to be made available to encourage that activity.

HIMSS would support efforts to provide financial incentives to those care settings that have lagged behind in adoption of certified electronic health records (CEHRT), such as post-acute care that did not previously receive federal incentives. Concerns with the proposed implementation timeline are further stressed in this scenario. Two significant shifts that should be considered are the extensive changes in both the Skilled Nursing Facility and Home Health Prospective Payment System (PPS), set to go into effect October 1, 2019, when providers will be faced with an enormous challenge of adjusting to new administrative practice requirements in those settings. One suggestion is to provide these settings with a longer and more gradual, ramp-up transition period as well as resources to facilitate their achievement of the standards required for compliance. It will be very challenging for providers and practices in the post-acute care realm to sprint to a significant level of preparedness from a business or practice standpoint.

An additional suggestion for this incentive would be a percentage increase in reimbursement to providers who electronically exchange or otherwise make available data electronically through the use of CEHRT. Advancing interoperability across the care continuum requires providers to work together across settings. As such, CMS could consider ways in which the Quality Payment Program (QPP) could be leveraged to help further incentivize adoption of health information and technology while increasing coordination/collaboration.

Within the Merit-Based Incentives Payment System (MIPS), CMS could create additional incentives for acute care providers to form and support partnerships with other care settings by offering additional points for those who successfully exchange data in a timely manner with providers in other care settings. Right now there are limited opportunities for other care settings to participate in advanced alternative payment models (APMs). CMS should work to develop advanced APMs that incorporate these other care settings and consideration should also be given to models that allow a more direct sharing of payments to other care settings across the continuum.

Specific to the post-acute care (PAC) setting, HIMSS would also support actions that would enable hospitals and physicians to collect and electronically exchange PAC standardized patient assessment data elements in their EHRs. Under the IMPACT Act, CMS has already created the Data Element Library to standardize the reporting of quality data across the PAC domains, HIMSS

encourages CMS to look at expanding this library to the inpatient and outpatient domains. HIMSS recognizes that sharing information in a consistent manner will enable a longitudinal approach to care, and would be an important step as PAC moves towards adopting new payment models.

HIMSS suggests this change be made in a staged manner, by prioritizing subsets of data. We suggest CMS start with information that is commonly collected for specific categories of patients (e.g. elderly with certain chronic conditions) that would be valuable to and could be leveraged by providers regardless of care setting. Since some of this information has already been standardized and tested, it could be leveraged for subsets of patients commonly treated by both acute and post-acute settings. Once this data set has been identified, it can be added to the US Core Data for Interoperability (USCDI) and become part of the common data classes for sharing moving forward.

Innovation Center Request for Information

HIMSS members continue to show a strong interest in seeing the models from the Innovation Center succeed. Developers are constantly investing significant time and resources in development associated with new demonstration projects, frequently including functionality or measures that are not already part of the Certified Electronic Health Record Technology (CEHRT) program. HIMSS remains committed to supporting the nation's best interest in helping identify more effective payment models that better address the challenges of lowered costs and improved patient outcomes, and our members will continue to devote extensive effort in this continued push toward value-based payment which these models are intended to support.

In recent years, there has been frustration from our members around the work done by the Innovation Center, as they have not felt that they have been part of the conversation during the development phase of new or revised programs, but rather only afterwards, when it is too late for our practical input to be considered. HIMSS would strongly suggest that the Innovation Center program teams consult with stakeholder experts as ideas are first being considered receive additional expertise on everything from workflow implications to quality measure feedback. As an added bonus, this approach would allow developers additional time to redesign or develop solutions that will enable greater program success, especially for models designed for non-certificated health care settings such as behavioral health and PAC.

We do appreciate the question about the incorporation of more social determinants of health (SDoH) data, such as that related to school, housing, finances, environment and food insecurity. We believe this is an important area to explore, and we must all recognize that many of the ideas in this area would require extensive technological investment by the software development community, which would take time. It may not even be clear where to store this information in an EHR, for example, and this would be a topic on which we would wish to engage industry stakeholders to be mindful of usability implications. There are also well-recognized but sizable workflow and privacy concerns related to the capture of this data.

We suggest that the industry think critically about what information would be most valuable, how and when it could best be collected, and how to connect clinicians to other support services in the region to allow them to act on the information when it is presented to them. It is certainly clear that standards currently are not well-articulated to capture or transmit this type of information, which frequently comes from non-CEHRT sources.

It has been suggested that an appropriate repository for SDoH data would be with the health plans, rather than placing EHRs at the center of the solution. Health plans, through case management and disease management efforts, would be most likely to take a holistic view of the patient in and outside of their care experience, and be able to act on circumstances affecting their health outcomes. Where relevant and actionable, mechanisms such as APIs could possibly be used to make that data available to clinicians within their EHRs, but keeping the health plan in the middle of this process would alleviate the challenge of defining where within the EHR to store the data, etc. HIMSS notes that standards for SDoH content should also include a separate risk factor. For example, a person may be homeless, living with relatives, insured and not at risk, whereas a person could be affluent, but have food access issues like in rural areas. Without the risk factor as a separate modifier, there could be unintended consequences, like profiling and the best intentions of SDoH could be undermined.

Patient Matching Request for Information

We are pleased that CMS (along with ONC) is considering more action on patient matching by seeking comment in this proposed rule. As we scale towards nationwide exchange, patient matching accuracy will only degrade further as more enterprises contribute errors and these errors compound, unless more action is taken on this critical patient safety issue. Poor patient matching can easily lead to patients receiving erroneous care or not receiving care they need. Whether matching errors lead to duplicate records or record overlays, patients who are not correctly matched to their records within and across healthcare systems and providers will ultimately not receive optimal care.

It is clear to HIMSS, as well as other stakeholders, that patient identification and matching remains a paramount challenge to information exchange and optimized patient care. HIMSS has long been involved in leading private sector efforts to improve patient matching, including funding an Innovator-in-Residence at HHS who worked on this topic. It was the work of the HIMSS Innovator-in-Residence that led to the ONC [Patient Matching Algorithm Challenge](#) in 2017.

This effort helped to bring greater transparency and data on the performance of existing patient matching algorithms, and spur the adoption of performance metrics for patient data matching algorithm vendors, as well as positively affect other aspects of patient matching such as de-duplication and linking to clinical data. Given that ONC has an infrastructure created by this challenge, it is important that HHS use the infrastructure for continued analysis and work on matching, potentially even with an updated challenge. Consideration should also be given to evaluating and expanded set of identifiers for use in the matching challenges, ranging from things like biometrics to height to less commonly used demographics, such as mother's first name, which is already being used in the California Medicaid programs. It is critical that this work continue to be led by the private sector in coordination with our federal partners.

Across the healthcare sector, there are a broad range of patient matching solutions commercially available. Some are stand-alone component products that focus just on patient matching, while others can be found embedded within the EHR platforms. Since there is no recognized authority or measure for patient matching capability, no organization can make a fact-based decision about which technologies work well and which do not. Many health organizations do not realize that there are differences in performance, and, ultimately, that they have a serious patient matching problem until it is too late.

Improving patient matching by standardizing demographic data means the benefits will mostly be realized by those organizations using the less sophisticated patient matching tools. Today, the higher performing technologies already accommodate "dynamic standardization" which formats demographic attributes consistently prior to any match algorithms being applied.

HIMSS strongly supports the use of matching algorithms as part of an overall patient matching strategy. However, we think that a specific mandate of a specific patient matching algorithm at this time is premature, especially considering there is no current way to benchmark the accuracy of those algorithms. HHS should work with the private sector to create a benchmark measurement for algorithms that have been and will be developed. This benchmark would help providers, organizations, and potentially CMS decide which algorithm to use moving forward.

These patient matching algorithms could be improved with more standardized data elements. HIMSS offers these additional data elements as a suggestion to improve patient matching: maiden name, multiple birth indicator, birth order, telephone number types (specifically mobile), and email address. More generally, data collection standards and their consistent application by health plans, providers, and exchange organizations are a critical determinant to matching accuracy. HIMSS believes the biggest opportunity to immediately enhance matching rates is standardized formats for demographic data among data sharing participants.

We would like to thank CMS for this opportunity to comment on the proposed rule as we strongly support its focus on interoperability and patient empowerment by providing them access to their health information. We welcome the opportunity to meet with you and your team to discuss our comments in more depth. Please do not hesitate to contact Jeff Coughlin, Senior Director, Federal & State Affairs, at 703.562.8824, or Eli Fleet, Director, Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,

Harold F. Wolf III, FHIMSS
President & CEO
HIMSS