June 25, 2018

Submitted via www.regulations.gov

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1694-P; Request for Information on Promoting Interoperability and Electronic Health Care Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

Dear Administrator Verma:

Thank you for the opportunity to provide feedback on your recent Request for Information (RFI) on promoting interoperability and electronic health care information exchange. We appreciate your leadership and commitment to bold action that breaks down barriers to realizing the full potential of health care data and technology.

Representing many different parts of the health care system, our organizations are united in the belief that we must collaborate in building the infrastructure to share data – the backbone of our collective efforts to improve quality, reduce total cost of care, improve patient experience and finally bring health care into the digital age. We support the proposal to require data sharing related to readmissions, improved care coordination and quality, and a reduction in unnecessary or even dangerous care, as described below, because it represents an important first step in forcing change to a system that has been too slow to evolve in a way that puts the needs of patients first. We believe that the Administration needs to finalize this proposal, and then keep pushing to unlock the data currently available in the health care system to enable patients and their providers to seamlessly access and share their digital health information.

Today, virtually every entity in the health care system is developing and assembling their own store of patient data. Despite its incredible potential to improve health and health care, the vast majority of this health information is not being used in a way that leverages the ability of data to guide and transform care. The promise of value-based care will not be realized until health care data generated by one provider is shared in a way that unlocks the value for other providers and the patient.

CMS Proposal to Require Information Sharing for Readmissions:

This Administration has a unique opportunity to address the current fragmentation of our health care delivery system by requiring that providers share data to enhance patient care. As you know, an inpatient hospital stay is one of the most significant experiences in a patient's health care journey – both medically and financially. As we move toward a value-based care system, it is important for a patient's health care "quarterback" – often a community practitioner – to have real-time, electronic information about major health care incidents so that they recommend and

coordinate appropriate follow-up care and help prevent unnecessary downstream health care utilization such as readmissions.

Given the unique health and safety considerations related to an inpatient stay, we support the use of health and safety standards (i.e., Conditions of Participation) to require hospitals to electronically share real-time information with the patient's community provider(s) when a patient arrives in the emergency department, is admitted or discharged from the hospital or transferred to another facility (ADT alerts). We believe that such action is necessary as federal incentives and penalties (e.g., Meaningful Use, funding for state health information exchange governance and infrastructure) have not resulted in universal hospital adoption of this standard of care.

There is some evidence, however, that tying reimbursement to information exchange requirements results in significantly greater rates of health care data exchange. For example, Maryland's ability to achieve a 6.5% reduction in hospital admissions was supported by a statewide all-patient all-hospital notification system powered by hospitals' ADT real-time data. In Maryland, approximately 70% of all Medicare discharges have an associated notification routed to a primary care provider. In Florida, the Agency for Health Care Administration relied on its Low Income Pool authorities to require hospitals to share ADT data, creating a real-time notification network which covers 95% of the acute care hospital beds in the state. In Tennessee, Connecticut, and North Carolina, the state hospital associations have taken the lead and partnered with Medicaid and outside vendors to pursue a real-time notification networks in which all of the hospital association members (and many of their post-acute care partners) will participate. In New York, Statewide Health Information Network for New York (SHIN-NY) has implemented a notification service within and among the 8 RHIOS that serve the state. ADT notification use by providers in New York has been on the rise in recent years, with the network-of-networks reporting a 95 percent jump in ADT notification use from 2016 to 2017.

The same or greater levels of information sharing could be achieved across the country with bold action from CMS. In its RFI, CMS asked for input on using health and safety standards to mandate information sharing in three specific instances: 1) requiring hospitals to electronically transfer medically necessary information to another facility upon patient transfer or discharge; 2) requiring hospitals to electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and 3) requiring hospitals to make certain information available to patients or a specified third-party application (for example, required discharge instructions via electronic means if requested).

The undersigned organizations support greater information sharing around each of these three use cases and recommend the following.

1. **CMS should adopt the following standards requiring hospitals to release ADT data:**

   - **Presentation in Emergency Room/Admissions:** The hospital must send real-time electronic notification that a patient has presented in the emergency room and/or been admitted to practitioner(s) responsible for the admitted patient's care.
   - **Discharge to Home:** The hospital must send real-time electronic notification of discharge to practitioner(s) responsible for the discharged patient's care. The hospital must also electronically send a copy of the discharge instructions and the discharge summary within 48 hours of the patient's discharge.

- **Transfer of Patients to Another Health Care Facility**: The hospital must send necessary medical information to the receiving facility at the time of transfer, and must send a real-time electronic notification of the transfer to the practitioner(s) responsible for the transferred patient's care.

2. **CMS should allow hospitals to meet these conditions over time (for example, by phasing in notification for greater numbers of patients over time) using existing health information exchange networks, private sector partners, or direct connections to community practitioners.** Such an approach gives hospitals and community practitioners time to develop the processes and infrastructure necessary to meet such a requirement. Existing community networks are preferred where available.

3. **CMS should require hospitals to make certain information electronically available to patients within 24 hours, such as discharge instructions and a summary of care, including through a designated third-party tool of their choice if desired.**

We encourage CMS to focus on policy options that are practical and achievable for hospitals without extensive additional work or substantial additional cost. The goal is to create a universal and consistent set of expectations that support patient safety. The pathway we propose aligns with where the market is going, relies on extensively adopted national standards and is consistent with requirements hospitals must already meet through meaningful use and other programs.

CMS Should Finalize this Proposal, and Go Further:

We believe that tying information sharing to Conditions of Participation would be a tremendous benefit to millions of Medicare and Medicaid patients across the country. In addition, we recognize that CMS has other levers that should be used to facilitate greater data sharing and interoperability, including requiring the use of 2015 Edition Certified EHRs and aligning requirements in the Quality Payment Program, the Promoting Interoperability program, and other quality programs such as STAR ratings. In addition to strengthening data sharing requirements in Conditions of Participation, we urge CMS to take additional action to align each of these programs with our national health care data and IT goals.

Conclusion:

Now is the moment for a focused and rigorous effort to liberate the data currently available in the health care system to enable patients and their providers to seamlessly access and share all their digital health information. We believe the time is right to move past the current rigid and siloed system into one prepared to take advantage of all the opportunities made available in our digital age. We thank you again for your leadership and bold action to realize meaningful change.

Sincerely,

Accountable Care Options
Aledade
American Academy of Home Care Medicine
Atlantic ACO
Audacious Inquiry

Beth Israel Deaconess Care Organization
Biden Cancer Initiative
BJC HealthCare ACO
Blue Shield of California
Cambia Health Solutions
Caregiver Action Network
CHESS
Chronic Care Management, Inc.
Coastal Carolina ACO
Community Care Collaborative of Pennsylvania and New Jersey
Delaware Valley ACO
Elation Health
ElevatingHOME/VNAA
Florida Association of ACOs
Healthix
Independent Healthcare Partners
Intel
Iora Health
Kentucky Primary Care Alliance ACO
Keystone ACO
Lancaster General Health Community Care Collaborative
MaineHealth Accountable Care Organization
Manifest MedEx
Mental Health America
Missouri Health Connection
National ACO, LLC
National Association of Accountable Care Organizations
National Association of Mental Illness
National Council for Behavioral Health
National Partnership for Women & Families
NEQCA Accountable Care
New York eHealth Collaborative
North Collaborative Care
Northern Michigan Health Network (NMHN)
OneHealth Nebraska
Patient-Centered Primary Care Collaborative
PatientPing
Quality Independent Physicians ACO
Reliance ACO
Rhode Island Quality Institute
RGV ACO Health Providers, LLC
Saint Francis Healthcare Partners
The Health Collaborative
Tidewater ACO
Triad HealthCare Network
Trillium Health