



One Prince Street
Alexandria, VA 22314-3318
T 703.838.0033
F 703.548.1890

June 3, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of AMGA and our members, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organizations 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" (CMS-9115-P).

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems, representing approximately 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, patient-centered medical care in a cost-efficient manner.

CMS explains that its rationale for the proposal is that patients cannot easily access their complete health record. A major challenge to addressing this issue is that pieces of information are kept in various, discrete, unconnected repositories that do not follow the patient through every encounter with the healthcare system. AMGA shares this concern and approaches it from the perspective of our member multispecialty group practices and integrated healthcare systems, which deliver care through innovative practice designs and models based on care coordination and population health. To employ such care delivery models successfully, AMGA providers require a comprehensive understanding of their patient population. CMS stated it wants patients to have the ability to "move from health plan to health plan, provider to provider, and have both their clinical and administrative information travel with them throughout their journey." AMGA and our members share this vision, and I offer these comments to the proposed rule and the accompanying Requests for Information (RFI) from the conviction that the regulatory framework for health information technology and interoperability should foster care coordination and enable providers to shift their practices into care delivery models that are centered on value.

Providers are best positioned to deliver high-quality, patient-centered care when equipped with the relevant patient information at the point of care. AMGA members consistently have cited

incomplete information regarding the patient population as a significant barrier to the move to value-based care. These comments provide recommendations to ensure AMGA members and all other healthcare providers have access to the data they need to successfully provide care in value-based models. AMGA understands that the proposals apply to the major federal healthcare programs—Medicare Advantage, Medicaid, the Children’s Health Insurance Program (CHIP), and insurance plans offered on the federally facilitated exchanges. Our members also require access to data for patients who are commercially insured, which is outside the CMS’ purview. However, we anticipate that they will follow CMS’ example, demonstrated in this proposed rule, in moving the healthcare system to value.

Key Recommendations

AMGA is pleased to offer the following recommendations:

Application Program Interface (API): AMGA supports the proposal to allow patient access to openly published APIs, but recommends that CMS develop a certification program for APIs to reduce potential burden and liability on providers. Providers should not be liable for misuse of patient data that is shared via a third-party application based in API technology.

RFI on Information Sharing Between Payers and Providers Through APIs: Access to data from all payers has been a longstanding priority of AMGA. In developing standards for providers to benefit from APIs, CMS should require that payers share all administrative claims data with providers. Sharing such data will improve patient care and reduce unnecessary services.

Conditions of Participation for Hospitals: CMS should finalize its proposal to add a new standard to require hospitals, as a condition of participation in federal programs, to send electronic patient event notifications in response to an admission, discharge, and/or transfer.

RFI on Advancing Interoperability in Innovative Models: CMS regulations for the Quality Payment Program that require 75% of clinicians in an Advanced Alternative Payment Model (APM) to use certified electronic health record technology (CEHRT) are unnecessary, as assuming financial risk in a model offered by CMS is not possible without a robust information technology infrastructure, making a threshold requirement superfluous.

RFI on Policies to Improve Patient Matching: AMGA members understand the importance of appropriate patient matching and, therefore, are supportive of efforts related to auto-matching and developing a common algorithm.

Public Reporting on Information Blocking: AMGA supports the proposal to indicate on Physician Compare whether a physician engages in information blocking.

Application Program Interface

CMS is proposing to require regulated entities (defined as Medicare Advantage (MA) organizations, state Medicaid fee-for-service programs, Medicaid managed care plans, CHIP managed care plans, etc.) to “implement, test, and monitor” an openly-published API that is accessible to third-party applications and developers. The API would be required to meet the interoperability standards as proposed by the Office of the National Coordinator (ONC) in its related proposed rule. CMS also is requesting comment on the type of data to be made available. The proposal is intended to increase patient access to health information and notes that patients are “increasingly accustomed” to accessing a range of personal records, including banking and credit information. AMGA supports this proposed requirement, as ensuring patients have access to their protected health information (PHI) will aid in the transition to value-based care. AMGA believes that as these APIs are developed and implemented, providers also will benefit from the ability to more seamlessly transmit and share data on shared patients.

There is concern that existing and proposed regulations do not address possible obligations from providers and health systems to work with third parties to ensure their products work with their existing information technology systems. As it stands, providers face difficulties in accessing data on their patients as they move throughout the healthcare system. Third-party developers will face significant technical challenges in developing an application that tracks patient data and is consumer-friendly. Despite these challenges, AMGA supports this concept. The data available through an API is the type of data our members rely on (and seek access to) to conduct predictive analytics for population health and care management. However, our members’ experience indicates that most vendors have difficulty in accessing adjudicated claims data, which is essential to successfully assuming risk. Used in conjunction with other information, such as clinical data, AMGA members would be able to continue their transition to value-based care. As it stands, our members report that difficulty in obtaining such data is a serious barrier to assuming financial risk in a value-based model of care.¹

To reduce potential provider burden with the open API proposal, CMS should clarify that providers will not face any additional liability for PHI that is accessed via a third-party application. CMS does note at *Federal Register* page 7621 that Office of Civil Rights (OCR) guidance indicates that “covered entities are not responsible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules for the security of PHI once it has been received by a third-party application chosen by an individual.” Beneficiaries likely are unaware of this guidance, and any education and outreach campaign surrounding the availability of third-party applications must explicitly disclose who is liable, as well as who is not. Further, CMS should clarify that providers are not obligated to provide technical support to any third-party developed application that accesses and/or transmits data via the API. CMS also should clarify that declining to support a particular vendor’s product would not constitute information blocking.

As covered entities under HIPAA, AMGA members are experienced with the patient protections in place. CMS correctly identifies in the proposed rule at *Federal Register* page 7635 that MA organizations, state Medicaid programs, and the other listed applicable payers ultimately are responsible for ensuring sufficient protections of PHI.

¹ [Taking Risk, 4.0: Clearing a Pathway to Value-Based Care](#), Speed, C. and Stempniewicz, N. May 2019

Request for Information on Information Sharing Between Payers and Providers through APIs

CMS is seeking comment for possible consideration in future rulemaking on the feasibility of providers downloading data on a shared patient population via an API. AMGA and its members are invested in the transition of the healthcare system to one rooted in value. AMGA believes there is significant potential for APIs to facilitate data sharing among all stakeholders of the healthcare system, which is particularly important in designing care delivery models that address population health.

Access to claims data, including commercial claims data, would provide AMGA members with a broader perspective on all the services a patient has received. These services, which may include preventive screening exams and tests, are not always captured and recorded in an electronic medical record, particularly if the services were provided by a clinician that does not have a relationship with one of our members. Payers, however, have data on the types of services a patient has received. The payer has a record of every encounter and every prescription filled unless the care is paid entirely on an out of pocket basis. Sharing this data via an API would offer providers the ability to view in “real time” the care a patient has received. Reviewing this data will inform provider’s care decisions and has the benefit of helping to reduce test redundancies and unnecessary procedures.

Sharing claims data through an API ensure providers have full access to a patient’s medical history, which enables providers to ensure their patients are receiving the most appropriate care. The data also informs population health efforts, which requires both access to claims data and clinical data. Relying solely on clinical data in a provider’s medical records is insufficient to develop a population health strategy. However, when paired with claims data, providers have a powerful tool to manage the health of a population, particularly for chronic disease. CMS should require that payers share all administrative claims data with providers and AMGA believes APIs can help facilitate such information sharing.

Health Information Exchange and Care Coordination Across Payers

CMS is proposing a new requirement for MA plans, CHIP managed care entities, and qualified health plans on the federally-facilitated exchanges to maintain a process to coordinate care among plans by exchanging, at a minimum, the U.S. Core Data for Interoperability (USCDI) at the enrollee’s request. Electronic health information exchanges (HIEs) allow providers to appropriately access and securely share a patient’s information. AMGA appreciates the work and potential of HIEs, which allow clinicians and patients to access and securely share the patient’s medical information. At issue, however, is the development and continued viability of such HIEs. As noted in our June 25, 2018, response to CMS’ RFI on promoting interoperability, our member medical groups have reported difficulty in successfully using an HIE to share patient data in real time. Addressing the legal requirements to participate in the HIE has been a time-intensive endeavor which delayed participation.

Revisions to the Hospital Conditions of Participation

CMS is proposing a revision to the Conditions of Participation (CoPs) for Medicare- and Medicaid-participating hospitals that requires hospitals to send electronic notifications in the event of patients’ admission, discharge, and/or transfer to another healthcare facility or to a community provider. Access to such information is critical for providers who deliver care in a

value-based model. In addition, the proposed revision could result in severe penalties for noncompliant hospitals.

AMGA appreciates that the CoPs are among CMS' most powerful policy levers. Simply stated, hospitals must meet Medicare's CoPs to be eligible for Medicare payment. The standards, as established in the CoPs, are sets of requirements for acceptable quality in the operation of healthcare entities.

As noted in our response to the RFI that sought comment on possible revision to hospital CoPs that was included as part of the FY 2019 Inpatient Prospective Payment System proposed rule, appropriately managing hospital admissions, discharges, and transfers is a vital aspect of any providers' ability to deliver care in a value-based delivery model.

As AMGA has argued on several previous occasions, any definition of successful pay-for-performance, accountable, or value-based care delivery must include the effective management of hospital discharge transitions and the reduction of preventable hospital readmissions. This requires the ability to utilize electronic health information to guide and transform care delivery, particularly when an acute stay is involved. Specifically, it means providers need the ability to quickly, or in real time, communicate patient data between and among emergency departments, inpatient units, ambulatory facilities and/or physician offices via the use of Admission, Discharge and Transfer (ADT) alerts. AMGA members, particularly those in value-based contracts, rely on the ADT alerts to appropriately manage care transition and identify potential utilization concerns. ADT alerts also offer an opportunity to prevent unnecessary hospital admissions.

The proposed changes to the CoPs for providers and facilities are a significant step toward ensuring effective population health initiatives in value-based models. CMS' proposal is limited to hospitals that already possess electronic health records with the capability to meet the requirements. The proposal should be finalized. Importantly, this revision to the CoPs confirms CMS' commitment to the move to value-based care.

Request for Information on Advancing Interoperability in Innovative Models

CMS plans to use Center for Medicare and Medicaid Innovation (CMMI) authority to test ways to promote interoperability across the healthcare spectrum and is seeking comments on general principles for promoting interoperability. As the proposed rule notes, these models have the ability to bring together providers from various points on the care continuum and can serve as a template for how interoperability can move forward for the rest of the care delivery system.

CMS regulations for the Quality Payment Program require that 75% of clinicians in an APM use CEHRT. AMGA believes this requirement is unnecessary. Such models inherently rely on the successful use of electronic health records and other health information technology to manage patient populations. Assuming financial risk in any value-based model is not possible without a robust information technology infrastructure, making a threshold requirement superfluous.

Request for Information on Policies to Improve Patient Matching

CMS requests information on how it can leverage its authority to improve patient identification. AMGA believes that accurate patient matching is essential to care coordination and value-based models of care, as such well-coordinated delivery models rely heavily on appropriate patient information being transmitted among providers. Inaccurate patient information can be harmful

to patients who may receive care that is not appropriate or who fail to receive the care they need. Inaccurate matching may cause unnecessary testing or services, resulting in higher costs for patients, providers, payers, and, ultimately, the healthcare system. Inadequate patient matching also undermines the goals of care coordination.

Quality demographic data is necessary to improve patient matching. In this RFI, CMS asks if it should advance more standardized data elements across all appropriate programs for matching patient information.

CMS support of a standard format for demographic data used to identify patients is a reasonable starting point to enhance patient matching. AMGA recognizes the value that standardized demographic data has and sees a role for CMS and ONC in implementing these standards. While individual providers have worked to standardize the format of demographic data,² work can be done by CMS and ONC to ensure all providers follow a single standard. AMGA recommends that CMS review the recent recommendations made by the Health Information Technology Advisory Committee (HITAC) regarding the use of demographic data to aid in patient matching. For example, encouraging the use of the U. S. Post Office standardized addresses and including designations for both mobile and landline numbers have the potential to improve the accuracy of patient matching.³

Other strategies to improve patient matching could include efforts related to auto-matching and a common algorithm. Some providers use software that automatically identifies and matches patient records. These tools use algorithms to compare demographic data in patient records, but these algorithms can vary.⁴ CMS should coordinate with ONC to create guidance that address standardization of data elements, such as listing addresses in single or separate fields, and how to handle names with spaces, hyphens, or other characters.

Public Reporting on Information Blocking

CMS is proposing to indicate on the Physician Compare website whether clinicians, group practices, or other healthcare providers engage in information blocking. AMGA supports this proposal. Providing beneficiaries with such information can help them find providers that collaborate or coordinate with other providers. AMGA agrees with CMS' statement that patients may prefer to select clinicians or groups who coordinate care and "[do] not withhold information that may result in better care."

The proposal is based on clinician reporting which is required as part of the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS). However, only those clinicians who participate in MIPS report the necessary information under that category. This raises concerns that beneficiaries will not be able to determine if providers that do not participate in MIPS due to the low-volume threshold are engaging in information blocking.

² Government Accountability Office. Approaches and Challenges to electronically matching patient records across providers. January 2019.

³ Health Information Advisory Commission (HITAC). U.S. Core Data for Interoperability (USCDI) Task Force Recommendations. May 13, 2019.

⁴ Government Accountability Office. Approaches and Challenges to electronically matching patient records across providers. January 2019.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact Darryl M. Drevna, AMGA's senior director of regulatory affairs, at 703.838.0033 ext. 339 or ddrevna@amga.org.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA