Mehmet Oz, M.D. Administrator
Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-0042-NC Request for Information: Health Technology Ecosystem

Submitted electronically at regulations.gov

Dear Administrator Oz:

Phreesia appreciates the opportunity to provide feedback on the Request for Information (RFI) titled "Request for Information: Health Technology Ecosystem." Phreesia shares CMS's vision to maximize the potential of digital health technology, with a keen focus on a patient-centric digital health ecosystem and the transition to value-based care (VBC).

Founded in 2005, Phreesia offers patient-driven digital solutions for intake, outreach, education and more. Our products and services enhance the patient and clinician experience, drive efficiencies, and reduce healthcare costs while improving outcomes. Last year alone, we supported more than 170 million, or more than 1 in 7 patient visits across the country. We partner with more than 4,200 providers, including hospitals, health systems, Community Health Centers, and small and large primary and specialty practices across all 50 states. We also proudly serve the Centers for Medicare and Medicaid Innovation, state Medicaid and Health agencies, commercial payers, life science companies, and advocacy and professional organizations and associations.

Core to Phreesia is helping patients take a more active role in their care. As a digital front door, Phreesia assists patients with finding, scheduling, and accessing care whilst also understanding their coverage and financial responsibility. We also support patients and their care team optimize health outcomes through the collection of patient reported data and clinically proven patient activation, engagement, and education tools. Our platform is both patient and clinical staff facing and integrates with more than 80% of the U.S. electronic health record (EHR) market. It is this unique perspective that shapes our response to the RFI.

While we have selectively responded to CMS questions below, we want to say a word on the use of patient-facing apps. Patient-facing apps are but one albeit important tool for patients. However app-fatigue and reticence will limit uptake. We encourage CMS to also think about secure, non-app based digital tools that can also support improved

healthcare experience, increased access to care, chronic disease prevention and management, and improved healthcare outcomes at reduced costs. We are available to answer questions regarding this response and serve as a resource on HIT-related matters. Phreesia looks forward to working with CMS to push health information, technology, and interoperability issues even further to develop a flourishing HIT ecosystem that not only serves but empowers the patient and the clinical teams alike.

Sincerely,

Evan Roberts
Chief Operating Officer

PC-8. a. What data is valuable, but hard for patients and caregivers, or app developers and other technical vendors, to access for appropriate and valuable use (for example, claims data, clinical data, encounter notes, operative reports, appointment schedules, prices)?

The 21st Century Cures Act made great leaps forward in the sharing of health information to improve care, outcomes, and costs. However, in the eight years since its passage, the healthcare and technology ecosystems have evolved, as have the expectations for a system that further empowers patients, caregivers and clinicians alike. There are persistent gaps and challenges in data sharing and our health data infrastructure that harms patients' abilities to be active participants in their care, perpetuates administrative burden and hinders the actualization of a robust, market-driven healthcare information technology (HIT) ecosystem. Policies are needed to advance the access, exchange, and use of health information not covered today by the Cures Act. We recommend:

1. Unleashing data to support patient access, transparency, and empowerment while also achieving administrative simplification for clinicians and their staff. Phreesia suggests expanding Cures Act-like access, rights and responsibilities to data related to scheduling, appointments, and medical and prescription coverage and benefits information, including patient liabilities and out of pocket maximums.
2. Standardizing the maintenance, collection and use of this information
3. Enabling easy-to-use technical and operational access that exceed today's Cures Act standards given current, persistent problems
4. Establishing clear and meaningful enforcement mechanisms to deter information blocking

PC-8. b. What are specific sources, other than claims and clinical data, that would be of highest value, and why?

The specific sources include provider network information, provider schedules, and insurance coverage information, including prescription coverage, spanning benefits, deductibles and out of pocket maximums.

PR-2. What are obstacles that prevent development, deployment, or effective utilization of the most useful and innovative applications for physician workflows, such as quality measurement reporting, clinical documentation, and billing tasks? How could these obstacles be mitigated?

Obstacles that prevent the development, deployment, or effective utilization of the most useful and innovative applications for physician workflows include tenuous financial

conditions, persistent operational barriers to regulated data exchange, and a lack of access to other health information and data.

To address financial conditions, we encourage CMS to minimally ensure fair Medicare reimbursement rates not just for the adopted technology, but for all services provided. Secondly, we urge CMS to consider a limited, strategic incentive program to propel adoption of technologies and applications that align with CMS' objectives. Such a program could mirror Meaningful Use, but seek to promote other, CMS-aligned technologies.

Standardized access to EHR clinical information through APIs has been helpful in the adoption of some innovative applications, yet adoption remains constrained due to costs borne to enable standardized APIs. In addition, the time it takes to connect to standardized APIs upon development can be lengthy. These issues limit physician adoption and also stifle the development of a robust market-based HIT environment. CMS could further regulate the API enablement process and costs by building upon the conditions of certification requirements at 42 U.S.C. 300jj-11(c)(5)(D)(iv).

Since non-clinical data, such as appointment and benefits information, is not privileged by the same regulatory force as clinical data, there are even greater obstacles to the development and utilization of innovative technologies that could support access, transparency, patient empowerment and administrative simplification. Minimally creating an equal regulatory playing field will help solve some of these challenges. As an added benefit, if additional data is made available via standardized APIs, we would expect even more adoption of standardized APIs and less reliance on proprietary APIs.

PR-3. How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)? Please address all of the following:

a. Current challenges in accessing different data formats.

b. Impact on patient care quality.

c. Technical barriers to full data accessibility.

d. Cost or privacy implications of making all data formats interoperable.

e. Priority level compared to other interoperability needs.

It is very important that data exchange expectations be consistent regardless of geography else historical disparities could be perpetuated. Additionally, in Phreesia's experience it is important that the aforementioned data (i.e. scanned documents, faxed records, lab results, free text notes, etc.) be accessible for exchange for a few reasons. First, it's part of the holistic patient record and can help promote patient education and

empowerment, care coordination, and minimize redundancies. Second, equal access to this data furthers patient access and choice, including use of non-affiliated clinicians. These are all matters of the quality of patient care.

There are persistent accessibility and cost challenges despite progress by various standards-based organizations to standardize the semantics and syntax of these data specifically. Access to this data, is rarely available today since its not currently required. When available, it is often via expensive proprietary APIs. We encourage CMS to look at the regulatory levers that can be helpful to create greater access to this data and to treat the privacy of this data just the same as the other clinical data subject to data sharing today.

Ecosystem TD-1. What short term (in the next 2 years) and longer-term steps can CMS take to stimulate developer interest in building digital health products for Medicare beneficiaries and caregivers?

Phreesia thanks CMS for your interest in accelerating the use and development of digital health products for Medicare beneficiaries and caregivers. We ask CMS to consider the true technical and financial models necessary to support and sustain a Medicare-beneficiary and caregiver HIT ecosystem.

This entails leveling the playing field for a diverse, competitive digital health market by:

1. offering not only upfront, but lasting financial incentives to develop and use these technologies
2. unleashing clinical and nonclinical health data in a consistent manner
3. ensuring unform, affordable and timely access
4. maintaining and using meaningful enforcement mechanisms
5. ensuring policies create a robust, market-driven, competitive environment

TD-4. How can CMS better encourage use of open, standards-based, publicly available APIs over proprietary APIs?

Phreesia supports the broad adoption of FHIR-based APIs. The standard-based, publicly available APIs required by the Cures Act are a good first step, but enablement costs can be prohibitive and as noted earlier often entail elongated implementation timelines. CMS should consider additional ways to promote open, standards-based APIs by granting free access to a wider class of data already covered by the Cures Act or establishing low or reduced cost enablement fee guidelines. We also recommend that CMS create enforceable expectations for the timeliness of API enablement.

To further advance the adoption of FHIR-based APIs while fostering the interoperable HIT ecosystem envisioned by the RFI, CMS must embark upon a broader regulatory

effort to expand standards-based APIs to additional data, such as provider networks and scheduling, and additional actors in the ecosystem.

Finally, we encourage CMS to harness its vast tools to incentivize the use of standard-based APIs, such as add on payments, inclusion in quality measurement standards, as a condition of participation in CMS-governed programs and or as a condition of certification for certified HIT.

TD-5. How could a nationwide provider directory of FHIR endpoints improve access to health information for patients, providers, and payers? Who should publish such a directory, and should users bear a cost?

A reliable, standardized provider directory should minimally cover any providers participating in CMS governed programs, including the Marketplace, Medicare, Medicaid and CHIP. This will support CMS' program integrity efforts while also creating a digital path for HIT vendors to offer additional patient access, transparency and choice solutions. CMS has varying levers to ensure information is current and can generate the cost to cover a provider directory by establishing nominal user fees. If built, the volume of users could offset the costs. CMS should maintain the directory.

TD-11. a. Yes, EHI export capability should be revised to specify standardized API requirements for EHI export.

TD-18.a Could you, as a technology vendor, provide examples for the types of practices you have experienced that may constitute information blocking. Please include both situations of non-responsiveness as well as situations that may cause a failure or unusable response? b. What additional policies could ASTP/ONC and CMS implement to further discourage healthcare providers from engaging in information blocking practices?

While not information blocking, undue costs and delays to access data have the same chilling effect as information blocking. We strongly recommend that CMS host small listening sessions with exchange stakeholders to learn more and seek appropriate remedies.