June 3, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted electronically via https://www.regulations.gov

RE: (CMS-9115-P) 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 the Federally-facilitated Exchanges and Health Care Providers

Dear Administrator Verma:

The National Association of Accountable Care Organizations (NAACOS) is pleased to submit comments in response to the proposed rule, *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 the Federally-facilitated Exchanges and Health Care Providers*, as published in the March 4, 2019 Federal Register.[1] We appreciate the efforts of the Centers for Medicare & Medicaid Services (CMS) to ensure patients and vital players of their health teams have secure access to necessary electronic health information. Creating a truly interoperable health system has been a goal of every administration since President George W. Bush. Furthermore, the bipartisan goal of shifting to a value-based payment system won't be possible without improving the flow of health information among patients, providers, and payers.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals, and other providers to work together and take responsibility for improving quality, enhancing patient experience, and reducing waste. Importantly, the ACO model also maintains patient choice of clinicians. In order to ensure patients receive the right care, at the right time, in the right setting, ACOs need to know about a patient's care inside and outside of their network. That's why we embrace many of the concepts laid out in this CMS proposed rule and its companion regulation published by the Office of the National Coordinator for Health Information Technology (ONC) also on March 4, 2019.[2] NAACOS submitted comments in response to the ONC rule.

NAACOS is the largest association of ACOs, representing more than 6 million beneficiary lives through 330 Medicare Shared Savings Program, Next Generation Model, and commercial ACOs. NAACOS is an ACO

[1] https://www.govinfo.gov/content/pkg/FR-2019-03-04/pdf/2019-02200.pdf
[2] https://www.govinfo.gov/content/pkg/FR-2019-03-04/pdf/2019-02224.pdf

member-led and member-run nonprofit organization that works on behalf of ACOs across the nation to improve the quality of Medicare, population health and outcomes, and healthcare cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated, patient-centric care process.

Summary of Key Recommendations

- **NAACOS is very supportive of requiring hospitals to send electronic notifications of patient's admission, discharge, and/or transfer (ADT) to another healthcare facility or another community provider and urges CMS to finalize the proposal after adopting a few adjustments.**
- **CMS should make clear that ACOs, which represent groups of providers and suppliers and work directly on their behalf, are eligible to receive ADT notifications.**
- **NAACOS recommends CMS not finalize the stipulation that hospitals must have a "reasonable certainty" the patient's community provider can receive a notification.**
- **NAACOS encourages CMS to deem a hospital compliant if they send ADT alerts to an intermediary for distribution to their provider networks as long as that intermediary isn't found in violation of ONC's information blocking rules.**
- **NAACOS reiterates calls to extend event notifications to emergency department (ED) presentations noting that the technology in place for ADT alerts can be applied to other events such as ED visits.**
- **We recommend hospitals have multiple options to comply with the proposed requirement so they may pick the best option for working with their community providers.**
- **As the process of sending ADT notifications matures, work may need to be undertaken by standards-setting bodies like HL7, convened by ONC, to develop a more robust standard that would support the sharing of additional data points, including those outlined by CMS in the proposed rule.**
- **This important policy will need proper oversight to ensure it's carried out as intended, which is why CMS should clarify how this condition of participation (CoP) will intersect with ONC's proposed "information blocking" rules.**
- **CMS should make Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) feeds available to ACOs and other Medicare providers.**
- **CMS should be mindful the Innovation Center's work testing such concepts like new data-sharing standards doesn't create undue burdens and barriers to participating in models it tests.**
- **NAACOS is supportive of CMS's proposal to require health plans participate in a trusted exchange network or their choosing, enabling the secure, nationwide flow of information between plans and providers.**

Admission, Discharge, and Transfer Notifications

Proposals: CMS proposes to require Medicare- and Medicaid-participating hospitals and Critical Access Hospitals that utilize electronic health records (EHR) systems to send electronic notifications of patient's admission, discharge, and/or transfer (ADT) to another healthcare facility or another community provider. The notification must contain "minimum patient health information" and could be sent through an intermediary, like a health information exchange (HIE), or directly to community providers. The notifications would be required immediately prior to or at the time of the patient's discharge or transfer from the hospital. A hospital would only need to send notifications to those practitioners who have an "established care relationship" with the patient relevant to his or her care and for whom the hospital has "reasonable certainty of receipt."

Comments:

NAACOS is very supportive of this proposed change and urges CMS to finalize it after adopting a few adjustments. Requiring these notifications would alert ACOs to important changes in patients' health status and care management. Proper care coordination requires providers know where patients receive care and then work together to coordinate care. Because Medicare ACO programs allow seniors the freedom to visit any provider they choose, care delivery teams are often in the dark about other providers whom beneficiaries visit. Yet ACOs are still held financially accountable for these patients without knowledge about key encounters like hospitalizations and ED visits that allow care teams to follow-up with discharge instructions and ensure a more effective transition of care.

ADT information is vital to ACOs' success, and CMS should not delay the sharing of these vital notifications with providers who need it most to improve patient care. This policy supports CMS's efforts to promote value-based care, and the agency points to several peer-reviewed studies in the proposed rule citing this is a patient-safety issue.

That being said, there are ways to optimize the proposal. We urge CMS to adopt the below changes before finalizing this requirement.

ACOs as an Entity with Which to Share ADT Notifications

CMS proposes that notifications be sent "to licensed and qualified practitioners, other patient care team members and post-acute care services providers and suppliers…that receive the notification for treatment, care coordination, or quality improvement purposes." It's not crystal clear that ACOs would fall into that definition, making them eligible to receive ADT notifications. Federal regulations define ACOs as a legal entity comprised of Medicare providers and suppliers.[3] They are not providers or suppliers themselves. **CMS should make clear that ACOs, which represent groups of providers and suppliers and work directly on their behalf, are eligible to receive ADT notifications.** As such, we recommend language in §482.24 and similar sections be revised to include "intermediaries, such as ACOs," or to include reference to "intermediaries, such as legal entities comprised of Medicare providers and suppliers." Without this important change, ACO care management teams would be forced to wait on a physician's office to get a notification. Relaying that notification would add an additional burden to the physician.

"Reasonable Certainty of Receipt"

Among the stipulations that must be met to require an ADT alert be sent, hospitals must have a "reasonable certainty" the patient's community provider can receive a notification. While we agree that an exception may be needed when technical issues beyond a hospital's control prevent successful receipt and use of a notification, we are concerned that the "reasonable certainty" standard may not be specific enough to ensure the requirement has the intended effect on information sharing. This vague condition would be difficult for a hospital to determine on its own and could pose an additional burden on them to be liable for knowing this. **NAACOS recommends CMS not finalize the "reasonable certainty" requirement.**

In conjunction with the recommendation immediately above, CMS should consider other options replacing the "reasonable certainty" standard in the proposed regulation with an alternative option. **Specifically, NAACOS encourages CMS to deem a hospital compliant if they send ADT alerts to an intermediary for distribution to their provider networks as long as that intermediary isn't found in violation of ONC's information blocking rules.** A hospital would be compliant with the new requirement if they: 1) attest that they are not information blocking through the Promoting Interoperability Program; and 2) generate a notification and share it with the intermediary, but it is not ultimately sent because there is no subscribing provider.

[3] https://www.govinfo.gov/content/pkg/CFR-2014-title42-vol3/pdf/CFR-2014-title42-vol3-sec425-20.pdf

This is an important clarification that ensures hospitals receive credit if they are unable to comply through no fault of their own. The exclusive use of an intermediary is not a delegation of a hospital's responsibilities but does meet the CoP if the intermediary facilitates exchange of notifications in a way that meets the requirements. We also recommend CMS monitor the methods by which hospitals send ADT alerts and the associated costs for providers outside of the hospital who may have to utilize an intermediary to access the information.

Additional Event Notifications, Such as Alerts on Emergency Department (ED) Presentations
CMS is correct to state that ADT alerts could open the door for a wider set of hospital event notification including for patient visits to EDs. NAACOS and other groups last year called on CMS to include ED visits in event notifications as part of the agency's request for information on ADT alerts.[4] **We reiterate those calls noting that the technology in place for ADT notification can be applied to other event notifications such as ED visits.**

Timeframe for Implementation
The proposed rule is unclear when the proposed new CoP would take effect. **Many hospitals should be able to comply with these requirements today, and CMS should work to implement this new requirement expeditiously.** CMS should not wait to enact this CoP concurrently with many of the proposed requirements in the companion ONC rule. Furthermore, ADT alerts would be an invaluable tool for ACOs' ability to manage population health as CMS moves to place ACOs at higher levels of financial risk. If CMS wants to put ACOs under risk, they should give them resources needed to succeed.

Clarification on Compliance Options
CMS gives necessary flexibility to hospitals to comply with this rule, for example, by limiting it to hospitals with EHRs that have the capability to generate ADT notifications. The agency also listened to the calls of NAACOS when giving hospitals technology-neutral options to send alerts, including directly or through intermediaries like HIEs.[5] Some ACOs today connect directly with hospitals to receive ADT feeds. While some HIEs are highly used in certain markets, many areas of the country lack a well-functioning HIE. **We recommend hospitals have multiple options to comply with the proposed requirement so they may pick the best option for working with their community providers.**

But the open-endedness of the proposed new CoP might leave hospitals unfamiliar with how they'll comply with the new requirement, making them nervous since their participation in Medicare and Medicaid is at risk. **Therefore, additional written clarification from CMS is needed on the options hospitals have to share ADT alerts. This could be done either through sub-regulatory guidance or the preamble of a final rule.**

Future Standards Work
The proposed rule points to ONC data showing an ADT messaging standard has been widely adopted by EHRs.[6] This should be viewed as further evidence that most hospitals should be able to comply with the proposed requirement. But further development of this ADT message-sharing standard should be considered. **As the process of sending ADT notifications matures, work may need to be undertaken by standards-setting bodies like HL7, convened by HHS, to develop a more robust standard that would support the sharing of additional data points, including those outlined by CMS in the proposed rule.** For now, hospitals should be given options for sharing ADT messages, and CMS's requirements for data shared with notifications should be considered a floor, not a ceiling.

[4] https://www.naacos.com/assets/docs/pdf/SignOnLetterSupportingUseofCoPs.pdf
[5] https://www.naacos.com/naacos-comments-on-interoperability
[6] https://www.healthit.gov/isa/sending-a-notification-a-patients-admission-discharge-andor-transfer-status-other-providers

Future Oversight

This important policy will need proper oversight to ensure it's carried out as intended, which is why CMS should clarify how this CoP will intersect with ONC's proposed "information blocking" rules. That work from ONC seeks to limit the purposeful hindering of flowing patient data. CMS doesn't state how, or if, sharing of ADT alerts will be subject to information blocking rules, and it warrants the agency's consideration. Furthermore, CMS should consider a feedback mechanism for ACOs and community providers that have the ability to receive ADT alerts but have faced obstacles to timely notifications.

Give ACOs access to HIPAA Eligibility Transaction System feeds

In a further recognition of the value of event notifications for proper care coordination, CMS should make Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) feeds available to ACOs and Medicare providers. HETS allows providers to check Medicare beneficiary eligibility in real-time using a secure connection. Anytime a Medicare beneficiary visits a medical provider, including the ED, inpatient hospital, or free-standing facilities like imaging centers and ambulatory surgical centers, an ACO could be aware with access to this HETS feed. Such awareness would allow ACOs to communicate with treating providers at the hospital or elsewhere and to work with the beneficiaries to ensure optimal treatment, medication adherence, and follow up care. CMS's proposed requirement for sharing ADT alerts wouldn't provide such universal notification.

Similar to requiring hospitals to send electronic ADT notifications, ACOs' access to critical HETS information in real time would allow ACOs to further enhance care coordination, improve outcomes, and reduce costs. **Making HETS feeds available is an alternative to sharing ADT alerts that provides more actionable information to providers in a manner that's less burdensome for hospitals yet doesn't carry the same consequences to hospitals for compliance.** NAACOS believes this request is technologically feasible and could be achieved with little burden on the agency. At minimum, CMS could allow ACOs to tap into the system themselves to access the data, a request the agency has denied.

CMS evaluated this recommendation several years ago and determined that because these real-time inquiries do not identify if the patient is being scheduled for an event, for example in a future surgery, there are false positives that ACOs would be confused by. ACOs, on the other hand, say they could manage through other means to identify the likely positives that need action. The more accurate way to provide the real-time ADT notifications to ACOs would be to add a field in the HETS system to determine the status of the patient at the time of request. The admissions staff almost always knows if the patient is being concurrently treated or if they are checking eligibility for a future event. The HETS staff in previous discussions said they have no funding to modify the system and did not perceive the same value in providing this information. We urge CMS leadership to develop a mechanism to share more robust health data, including that from HETS, with ACOs in real time to enhance care coordination, improve outcomes and reduce costs.

Advancing Interoperability in Innovation Center Models

Proposals: CMS seeks comment on ways to promote interoperability in future models put forth by the Center for Medicare and Medicaid Innovation (Innovation Center), for example, by incorporating the piloting of emerging standards; leveraging non-traditional data like that from schools, or about housing and food insecurity; and leveraging technology-enabled patient engagement platforms.

Comments: NAACOS supports the Innovation Center's work to create novel delivery models that both reduce spending and improve quality. The Innovation Center can leverage the knowledge and experience of ACOs to further the transformation of our health system into one that better pays for value. NAACOS

continues to work closely with the Innovation Center to improve payment models such as the Next Generation ACO Model, Advanced Payment ACO Model, and Direct Contracting Model, among others.

CMS should be mindful the Innovation Center's work testing new data-sharing standards and platforms doesn't create undue burdens and barriers to participating in models it tests. These proposed CMS and ONC interoperability and information blocking rules should solve many of the data-sharing challenges that exist today and promote the secure access to and exchange of data between patient, providers and health plans.

If these rules are finalized and successfully advance data sharing, much of the Innovation Center's potential work in this area, for example requiring providers offer patients 24-hour access to their medical data, could be duplicative. Furthermore, providers' success in new payment models is dependent on having well-functioning health IT systems. **Therefore, additional requirements from the Innovation Center risk introducing more work and uncertainty into models with little benefit.** Additional mandates in this area could be burdensome, unnecessary, and hinder future participation in Innovation Center models.

Health Plans and Trusted Exchange Networks

Proposals: CMS proposes that payers in CMS programs participate beginning January 1, 2020 in a trusted exchange network which allows them to join any health information network they choose and participate in nationwide data exchange, enabling the secure, nationwide flow of information between plans and providers.

Comments: **NAACOS is supportive of efforts that allow data to follow patients as they migrate from health plan to health plan or age into Medicare.** If CMS's goals are achieved, providers will have greater access to patient claims history and encounter data when patients first present in the office, allowing for more optimal care. As commercial health plans become more involved in value-based care contracts, including ACOs, providers they work with will need more data on those commercial patients. CMS proposal is one way to allow ACOs better access to patient histories for care given with patients were covered by other health plans.

Information Exchange Across the Care Continuum

Proposal: CMS solicits feedback on several potential strategies for advancing information exchange across post-acute care (PAC) settings, including interoperability measure development and standardization of patient assessment data.

Comments: NAACOS appreciates the work of CMS to address the flow of electronic health information among all providers, including PAC settings and others not eligible for EHR Incentive Program, better known as "meaningful use." Well-coordinated care requires providers across the care continuum to work together to ensure patients get and stay healthy. The consequences of not managing patients' health can result in readmissions and other poor outcomes, as noted in the proposed rule. Much work has been undertaken to advance health IT use and interoperability in PAC settings, and CMS has an opportunity to help spur progress.

EHRs that serve acute providers and post-acute providers need better integration. CMS could consider a pilot to test the ability of PAC vendors to better consume data from the acute setting to improve care handoffs, efficiency, and outcomes. Some work has already been done at the state level, which could be a

starting point for pilots at the federal level. For example, Georgia has an effort around fostering information sharing across the care continuum[7]

CMS is wise to look first at certain patient assessment data elements required by the IMPACT Act of 2014 – as opposed to developing new measures fist – as it looks to develop health IT vocabularies across PAC settings. The agency should be cautious, however, of the administrative burden possibly placed on physicians and hospitals who would be forced to collect and electronically exchange subsets of patient assessment data. Some of this data may not be electronically captured now. CMS should keep new administrative burdens to a minimum.

CMS should also limit data elements to those with applicability with a broad set of acute and PAC providers. Functional status, medical conditions and comorbidities, for example, have meaning and clinical value across the medical landscape. Not all data points that interest PAC providers would be captured by or relevant to hospitals and physicians, and vice versa.

Conclusion

ACOs have been instrumental in the shift to value-based care, and a central part of their success – and in turn Medicare's work in transforming how health care is paid for – is securing the proper patient data on which to base decisions about their care. Work by CMS in this rule, paired with the work of ONC in its rule, should help to achieve the goals of a well-functioning health system. That's why it's important for the administration to adopt our recommendations to finalize certain aspects of this rule with necessary changes and proper oversight. Thank you for your consideration of our comments. Should you have any questions about this letter, please contact David Pittman at dpittman@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
National Association of ACOs

[7] https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/Concentration%202%20Communication%20Combined.pdf