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Advancing Health in America

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June 3, 2019

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

Re: RIN 0938-AT79, 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; Proposed Rule (Vol. 84, No. 42), March 4, 2019.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) multifaceted proposed rule to promote electronic health information.

The AHA fully supports CMS's intent to expand the ability of hospitals and health systems, health plans and others to share information that is useful in ensuring patients get the care they need and that it is safe and efficient care. However, we believe the desire for greater interoperability of information exceeds the infrastructure currently in place. Further, the conditions of participation (CoP) for hospitals, critical access hospitals and psychiatric hospitals are not the right vehicle to use in prompting hospitals to be interoperable. Additionally, the infrastructure to do what CMS proposes for post-acute care settings, Medicare Advantage (MA) plans, Medicaid, Children's Health Insurance Program (CHIP) and Qualified Health Plans (QHP) also is not in place yet. **The AHA urges CMS not to finalize the provision in this proposed rule that would make the electronic exchange of admission, discharge and transfer (ADT) information a CoP and to delay the provisions for the sharing of information by various kinds of health plans until feasible.**

Our detailed comments follow.

PROPOSAL TO MAKE EXCHANGE OF ADT INFORMATION A COP

We believe it is important to share patients' ADT information with those involved in the care of each patient, as well as with the patient. To do so through interoperable exchange of data is easier than through other means currently at our disposal, but requires the existence of an infrastructure that only is partially constructed at this time. Currently, many of our members are able to share electronic health record (EHR) information, including ADT data, with others in their geographic area through their regional health information exchanges or through services such as PatientPing.

CMS's proposed rule would impose additional requirements on hospitals as part of the CoPs and on QHPs, MA organizations, state Medicaid agencies, CHIP agencies and others to achieve greater interoperability. This rule must be assessed in relation to the Office of the National Coordinator for Health Information Technology's (ONC) proposed rule on information blocking; the Promoting Interoperability Program and its rules; the CoPs and anticipated amendments to those COPs that will come from the burden reduction rule proposed last fall; and the discharge planning rule that CMS proposed more than three years ago but has not yet finalized.

AHA and its members fully understand that allowing hospitals and other providers to share important information with each other in a timely and efficient manner is critical, and that doing so through an interoperable health information system would be easier than the current hodgepodge of communication strategies. It also is useful for patients to have access to their information. As shown in the recent survey we conducted with ONC, 71 percent of hospitals report that they are sharing information electronically with providers outside their system.[1] When it works, it is easier, more efficient and timelier than other ways in which patient information is shared.

However, CMS's proposal to make the transfer of ADT information a CoP is inconsistent with congressional intent for how the Department of Health and Human Services (HHS) would use the CoPs and how CMS would regulate the meaningful use of health information technology. Further, it assumes the existence of an infrastructure to make the exchange of such information routinely possible when that infrastructure is still being built. It also creates a situation in which hospitals trying to achieve compliance with this rule and the information blocking rule will find themselves trying to navigate through many redundant, conflicting and confusing requirements – all while risking their ability to participate in Medicare and Medicaid and incurring substantial fines. **We urge CMS to take a step back and consider how public policies can facilitate the development of the needed infrastructure rather than trying to force hospitals to create it under the threat of extraordinary penalties if they do not.**

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[1] Sharing Health Information for Treatment. http://www.aha.org/guidesreports/2018-03-01-sharing-health-information-treatment.

In Section 1861 of the Social Security Act, the HHS Secretary is empowered to establish "...such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution." This legislative language is the foundation for the CoPs for hospitals, psychiatric hospitals and critical access hospitals (hereafter referred to as "hospitals").

The exchange of information with others who have immediate responsibility for the care of the patient is important, and there are CoPs currently in place that dictate the exchange of critical patient event information with others caring for a patient, such as:

- Recognize the patient's right to have a representative of his or her choice *and his or her own physician notified promptly* of his or her admission to the hospital [§482.13(b)(4)];
- Have in place a discharge planning process that assesses the needs of the patient, screens for the risk of adverse events post-discharge, creates a discharge plan of care, and initiates implementation of that plan, *which includes communicating with the next care giver and the patient and/or family member* [§482.13(b)(4)];
- Transfer any necessary information to the appropriate site for follow-up care, including: (i) the reason for transfer or discharge; (ii) the effective date of transfer or discharge; (iii) the location to which the resident is transferred or discharged; (iv) a statement of the resident's appeal rights; and information on how to obtain an appeal form and assistance in completing and submitting the appeal request; and several other pieces of information[§482.43(d)];
- *Prepare and orient patients* to ensure safe and orderly transfer or discharge from the facility [§483.15(c)(5)]. (emphasis added)

While the above requirements focus on what information must be provided to ensure safe and effective care for patients, they are agnostic as to the mechanism by which the information must be exchanged. In contrast, CMS's new proposal focuses on the mechanism by which information must be shared, not on the improvements in care. CMS has not made any credible argument that sharing information via an interoperable exchange, rather than other methods, would lead to better outcomes. Thus, we do not believe that this proposal meets the intent of the legislative language for a requirement to be a CoP.

Congress in the Health Information Technology for Economic and Clinical Health (HITECH) Act gave the agency the responsibility for overseeing the use of EHRs. From that authority, CMS created the set of regulations now known as the Promoting Interoperability Program (nee: Meaningful Use Program). This is the vehicle Congress intended for the agency to use in regulating the exchange of information between hospitals, patients, other caregivers and others who may have a legitimate reason to view information about the treatment of patients, not the CoPs.

Further, CMS's proposal to create this CoP comes on top of existing programs and requirements to advance the interoperability CMS has established in the Promoting Interoperability Program. It is unclear why CMS has chosen to use a different mechanism entirely – the CoPs – to advance information exchange.

CMS should use one program to impose requirements related to the use of information technology rather than including some in the CoPs, some in the Promoting Interoperability Program and potentially some in other programs. When requirements for a set of activities are spread through different regulatory programs, it becomes confusing and difficult to navigate through the distinct and often competing requirements. **The AHA urges CMS not to create separate streams of regulatory requirements for interoperability. Continuing to align requirements for the use of electronic health information through the Promoting Interoperability Program exclusively will reduce confusion and eliminate unnecessary burden**.

UNFAIR PENALTIES

While we recognize that the exchange of ADT information likely has benefits for the patient and the entire care team, it is just one of many actions hospitals are taking to ensure the safe, high-quality treatment of patients. Arguably, many of those other actions are far more important to patient outcomes than the exchange of ADT information. Yet, when one looks at the conflation of the multiple rules that apply to the use of electronic patient data, it is easy to see that hospitals would be at risk for extraordinary penalties for failure to exchange ADT information electronically – penalties that could far exceed the appropriate penalties already established for failure to adhere to other critically important requirements.

For example, the proposed CoP would require hospitals to send ADT notifications to "licensed and qualified practitioners, other patient care team members, and post-acute care service providers and suppliers that receive the information for treatment, care coordination or quality improvement purposes, that have a care relationship with the patient, and for whom we have a reasonable certainty of receipt of the information."

Common scenarios for patients coming to hospital emergency departments (ED) include patients experiencing some symptoms, calling their doctor and then receiving instructions to head to the ED; or, a patient in an assisted living facility or nursing home experiencing symptoms and being sent to the ED. In such situations, the doctor or the nursing home often ask for a report on the disposition of the patient. In the event that the hospital made a mistake and failed to send the ADT via electronic transmission as described in this proposed rule, it would violate this CoP. If the hospital did not have a reason for its failure that fell into one of the exceptions in the information blocking rule, the hospital also would be at risk of being considered an information blocker. For the hospital, the ONC proposed rule dictates that the penalty for being an information blocker is to fail the Promoting Interoperability Program. The penalty for failing the

Promoting Interoperability Program is three-quarters of the hospital's market-basket update. **Based on the proposed inpatient payment rule for fiscal year 2020, that penalty would be 2.4 percent of its Medicare payments. Thus, hospitals are at risk of losing millions in Medicare payment for failing to exchange ADT information as part of the Promoting Interoperability Program**. Further, because the hospital would have certified that it was not an information blocker as a requirement of the Promoting Interoperability Program, it could potentially be liable under the False Claims Act, which carries a penalty of up to three times the amount of the claim and up to $11,000 per claim.

These are extraordinary penalties, especially in a field where 30 percent of hospitals have negative operating margins. By proposing additional penalties – to make the exchange of ADT information required as a CoP – CMS also would put a hospital's ability to participate in Medicare and Medicaid at risk. This could cause hospital closures and create access problems for patients. Moreover, the financial penalty is far stronger than other program penalties that are likely of greater importance to patients. Specifically, CMS's proposed policies put hospitals at far greater risk for failure to share ADT information than for failure to protect a patient's information, failure to publicly report on the quality it provides and excessive mortality rates.

With substantial penalties in existence as part of the Promoting Interoperability Program, it is unclear why CMS believes that it is necessary to add this CoP. Further, the potential penalties for non-compliance are so out of proportion to those for other actions that are critically important to patients, it makes one question why CMS has put such an emphasis on the transmission of ADT information. **The AHA urges CMS to rethink the signal it is sending to the field about where hospitals' priorities should be focused, and whether ADT transmission is, in fact, as important as the severe penalty provisions suggest.**

ARE EXPECTATIONS CLEAR AND FEASIBLE?

Hospitals and health systems view compliance with the CoPs as foundational to assuring the communities they serve that they are safe, high-quality care providers. To be able to comply, they must have a clear and unambiguous understanding of what is expected of them and how they will be judged. As noted above, the proposed CoP would require hospitals to send ADT notifications to "licensed and qualified practitioners, other patient care team members, and post-acute care services providers and suppliers that receive the information for treatment, care coordination or quality improvement purposes, that have a care relationship with the patient, and for whom hospitals have a reasonable certainty of receipt of the information."

The preamble to the rule suggests we will know who these individuals are by 1) asking the patient, 2) reviewing the patient's medical record history, or 3) using some other process of the hospital's own choosing. Each of these methods would work some of the time, but none of them would work all of the time. Patients or their family members may

be able to name the patients' doctor(s) or other caregivers in many cases. However, in the stress of a health crisis or as an effect of trauma, dementia or other challenges to mental acuity, they may not remember or be able to articulate the names and other necessary identifying information that would allow the hospital to know it is transmitting information to the right clinicians and organizations. A review of medical records may turn up a clinician from the patient's history, but there is no way of knowing from the record if this clinician continues to have a relationship with the patient. The patient may have chosen to discontinue his/her relationship with the clinician for any number of reasons, or the hospital may not be able to distinguish which "Dr. Smith" is the patient's Dr. Smith. These issues are amplified for hospitals that serve as regional or national hubs for care or that serve a "snow bird" or other transient population whose clinicians are unfamiliar to the hospital. And the transmission of this very personal information to the wrong individuals could violate the patient's trust in the hospital and the requirements of HIPAA.

It also is unclear what CMS's expectation is for how hospitals would transmit this information to the appropriate clinicians and organizations. In areas with an active Health Information Exchange that includes all of the clinicians and care-giving organizations in an area, or with applications designed to facilitate such exchange, it is relatively easy to communicate with any of the intended recipients who also are on the exchange or application. But for those patients whose clinicians are not on that exchange or a part of that application, an easy, secure path for transmitting patients' information does not exist. What is CMS's expectation for how hospitals would comply?

Finally, the rule suggests this transmission should happen when the hospital has a "reasonable certainty of receipt of the information." Yet, CMS neither provides information on what constitutes a "reasonable certainty" nor does it describe its expectations for how the hospital would form an opinion of the chances that the intended recipient could receive the information. It is important for CMS to articulate with some degree of precision what compliance with its CoP looks like. This proposed rule does not provide enough information for hospitals to know what is expected. **We urge CMS not to finalize this CoP**.

EXPECTATIONS OF SURVEY TEAMS

We also recognize that a hospital's compliance with the CoP is judged by a survey team. That survey team needs expertise, training and clarity regarding what they are looking for as evidence of compliance.

To judge compliance with the rule, surveyors would have to be able to see that hospitals sent ADT notices and review decisions where the hospital did not send the information. The rule potentially allows hospitals not to send the information if they do not have

patient consent to do so.[2] It clearly allows hospitals not to send if they do not have a "reasonable certainty" it would be received. Nothing in this rule makes clear what the expectations are for recording why the hospital did not forward the ADT information. EHRs do not have a field in which to capture the reason why the hospital staff believed that the potential recipient does not have the capacity to receive the ADT information or that patient consent was not obtained.

The AHA believes it is a mistake for CMS to make any part of interoperability, including the sharing of ADT data, a CoP for Medicare and Medicaid and urges the agency to withdraw this proposed rule and continue to articulate requirements for interoperability and use of EHRs in the Promoting Interoperability Program.

STRATEGIES FOR ADVANCING INTEROPERABILITY ACROSS POST-ACUTE CARE SETTINGS

In the proposed rule, CMS requests information for future rulemaking on strategies for advancing interoperability across care settings, particularly noting the importance for outcomes when patients move from an acute care hospital to a skilled nursing facility (SNF), inpatient rehabilitation facility (IRF) or long-term care hospital (LTCH) or if the patient receives home health agency services. CMS expresses concern that poor patient outcomes may result from poor communication among these providers.

The AHA supports CMS's goal of advancing interoperability in post-acute care settings. However, CMS first needs to ensure that the technological and organizational infrastructures exist to facilitate meaningful interoperability between post-acute care providers and general acute-care hospitals – critical building blocks that do not widely exist today.

THE CURRENT STATE OF POST-ACUTE CARE HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

Policymakers continue to assess the readiness of the post-acute care field to begin the electronic exchange of health information. In general, they have found that the field is substantially lagging behind general acute-care hospitals. Policymakers remain motivated to advance health information exchange in the post-acute care world as part of the broader effort to improve overall episodes of care. The government's own studies

[2] Page 7623 of the preamble to the rule says, "Under other laws, providers may need to obtain specific individual consent to obtain health information related to care provided by a behavioral health provider, treatment received at a substance use disorder treatment facility, certain 42 CFR part 2- covered diagnoses or other claims related information, or labs that suggest a part 2 diagnosis. We do not intend to expand any scope of authority to access patient data nor to contravene existing requirements related to disclosure of PHI under the HIPAA Rules and other legal standards, but instead specify a new and additional mechanism by which to share health information as directed by the individual, through the use of API technology in compliance with all existing federal, state, local, and tribal privacy and security laws."

have shown that more needs to be done to assist post-acute care providers in obtaining and using interoperable health information technology.

HHS Assistant Secretary for Planning and Evaluation (ASPE). ASPE has published several studies on health information technology and post-acute care, including *Health Information Exchange in Long-term and Post-acute Care Settings*[3]. This study found that despite the increased focus on the importance of post-acute care providers in the care continuum, their integration into electronic health information exchange still is in its infancy. Moreover, integration of post-acute care providers into electronic health information exchange activities generally is not the robust, bidirectional exchange typically envisioned in earlier studies regarding the potential for improvements in care delivery and outcomes.

The report also found that while post-acute care providers were sometimes involved in discussions and planning for electronic health information exchange in their region, they typically were not prioritized for inclusion. Additionally, since post-acute care providers were not eligible for EHR incentives, they often did not purchase *certified* EHR technology, necessary modules to support health information exchange or other technology solutions that would be needed to support exchange. Finally, some post-acute care providers were not yet convinced of the business case for health information exchange and/or wanted additional support (financial and technical) to implement EHRs, redesign workflows, and educate and train staff.

Government Accountability Office (GAO). A February 2017 report by the GAO[4] identified the following external factors that limit post-acute care use of EHR and the electronic exchange of health information:

- **Cost:** Post-acute care stakeholders have limited financial resources to cover the initial cost of an EHR, additional costs required to exchange health information and EHR maintenance.
- **Implementation of standards:** The variability in health data standards and the difficulty of finding health information relevant to post-acute care providers are concerns.
- **Workflow disruptions:** EHR implementation can require post-acute care facilities to alter daily work activities or processes, which can be disruptive.
- **Technological challenges:** Some EHRs are not capable of electronically exchanging health information.
- **Staffing:** The lack of staff with EHR management expertise and high staff turnover result in a constant need for staff training.

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[3] November 2015. https://aspe.hhs.gov/system/files/pdf/205271/LTPACsetting.pdf

[4] *HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings,* GAO-17-184: Published: Jan 27, 2017. Publicly Released: Feb 27, 2017, https://www.gao.gov/products/GAO-17-184.

The report notes that, "Even when providers adopt an EHR system, they may not be able to use that system to exchange health information with other providers, and the EHR systems will not necessarily be interoperable with other health IT systems, including EHRs and health IT systems belonging to laboratories, specialists, and post-acute care settings."

Agency for Healthcare Research and Quality (AHRQ). AHRQ also has weighed in on the topic of post-acute care and health information exchange[5] and found that:

- Electronic health information exchange for post-acute care is believed to be lower than EHR adoption rates.
- Interoperable health information exchange is rare in post-acute care.

AHRQ also found these challenges:

- Difficult to collaborate with a heterogeneous group with different points on the health information technology adoption spectrum (no adoption versus high adoption).
- No agreed-upon content for electronic health information exchange.
- Unclear if the sending site has what the receiving site needs.
- Limited or no financial support for health information technology investment and no compelling business case for health information technology investment by post-acute care.
- Need to identify workflows and connections needed to enable patient information to flow to the right place at the right time.
- Many post-acute care providers are unable to contribute anything to the state or local health information exchange, due to view-only capabilities.

Both our hospital and post-acute care members are making substantial investments to improve transitions of care across settings. However, the transitioning from the ownership of EHRs to actual information exchange to and from post-acute care providers remains limited. The biggest impediment to this exchange continues to be incompatible health information technology systems. To work around the limitations of the current system, some members report using "data extraction" software to access selected fields of desirable data from the medical record of the referring hospital.

As CMS considers moving forward, it must bear in mind that post-acute care providers' sizes and resources are highly variable, ranging from national chains that have invested many millions in building their own post-acute care health information technology systems to one or two site organizations with limited funds available for health information technology investment. AHA's 2017 Annual Survey of the hospital field found that almost 90 percent of IRF respondents use a certified EHR system, while only

[5] https://www.healthit.gov/sites/default/files/playbook/pdf/factors-contrib-hie-ltpac.pdf

57 percent of LTCH respondents have one. A November 2018 ONC Data Brief reported that 66 percent of SNFs and 78 percent of home health agencies used an EHR in 2017.

ADVANCING POST-ACUTE CARE INFORMATION EXCHANGE

To advance health information technology in the post-acute care settings, our members recommend:

- Greater policy requirements for health information technology vendors to ensure products that actually facilitate interoperability for post-acute care relative to the entire continuum of care.
- Investment of federal resources to encourage the development of effective post-acute care health information technology tools that advance true interoperability both for hospital-to-post-acute care and post-acute care-to-post-acute care health information exchange.

We also support the ONC effort to continue surveying post-acute care to continue tracking the rates of EHR adoption and the extent to which post-acute care providers are engaging in activities that demonstrate interoperability – specifically, sending, receiving, finding and integrating electronic health information.

IMPACT ACT REQUIREMENTS

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 mandated more consistent patient assessments across post-acute care settings to improve transitions of care and coordination over an episode of care. This process still is in the early stages with only one item implemented for two out of the five patient assessment domains.[6]

We do not support expanding hospital and physician interoperability requirements to include post-acute care patient assessment items, as post-acute care patient assessment items generally do not align with the clinical focus and protocols of general acute-care hospitals and physicians. In general, doing so would impose substantial burden on referring general acute-care hospitals, with no material improvement in the sharing of useful information.

One exception may be the patient assessment item **"**discharge assessment of functional status," which might be appropriate for consideration as an *optional* item for general acute-care hospitals because of the growing interest in making hospital discharges to post-acute care more evidence-based and consistent to improve

[6] So far, only these two IMPACT Act-mandated patient assessment items have been implemented: 1) a function process measure, Application of percent of LTCH pts w an admission and discharge functional assessment and a care plan that addresses function; and 2) a medical conditions and comorbidities measure changes in skin integrity PAC – pressure ulcers/injury.

transitions of care. Further, such data could be relevant under a possible new payment approach for post-acute care, such as a unified post-acute care prospective payment system, a payment model that is being developed per an IMPACT Act mandate.

Looking forward, CMS and RAND have a policy process underway to develop additional patient assessment items, which could potentially yield items that align with hospital and physician clinical processes and, therefore, perhaps their interoperability requirements. However, based on interaction with our members who are engaged in the RAND "beta test" being used to develop and test potential new items, we anticipate that only a small number of new items would be relevant to both general acute-care hospitals and post-acute care providers.

We are opposed to creating additional Medicare CoPs or conditions for coverage (CoCs) for post-acute care providers to promote interoperability of health information. This mechanism raises multiple concerns, including the absence of a technical and organizational infrastructure to enable electronic health information exchange, an impediment that is particularly acute for post-acute care providers. We articulated our opposition in several letters that responded to CMS's 2018 request for information on advancing interoperability of health information through CoP/CfCs, such as our Aug. 31, 2018, letter in response to the calendar year 2019 home health proposed rule.

OPEN API PROPOSAL FOR MA, MEDICAID, CHIP AND QHP ISSUERS IN FFES

The agency proposes to apply the same application programming interface (API) standards proposed by ONC to Medicare MA organizations, Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, CHIP managed care entities and QHP issuers in states utilizing a federally facilitated exchange (FFEs). We support the agency's aim to ensure alignment across insurers and providers**.** As detailed in our recent comments to ONC, neither the insurer nor provider alone hold all of a patient's data. While clinical information originates with one, or many, providers, much of the administrative data, such as a patient's coverage details, originates with the patient's health plan. This can cause friction as patients try to piece together disparate pieces of information to get the full picture of their care and their related financial obligations. Alignment in standards will help remove some of the friction in order to ensure patients have simple and easy access to their health information.

However, we are concerned that the ONC rule only proposes standards for sharing clinical data, whereas CMS is proposing that health plans would be required to make both clinical *and administrative* data available through the open API. While we do believe these data could be useful for patients for the reasons detailed above, we urge the agency to not require sharing of administrative data via an open API until CMS specifies a standard. Without standards and specifications, it is difficult for various parties to exchange this information in an efficient way. We are aware that CMS has utilized the Blue Button 2.0 API specification to make its own administrative data available, but it is unclear from CMS's proposal if it would require health plans to do the

same. **Consequently, in order to promote adequate pathways for sharing administrative data, CMS should prioritize adding administrative data elements – such as claims and encounter data, provider remittances and coverage details – to the U.S. Core Data for Interoperability (USCDI), which would lead to the development of FHIR financial resources and inclusion of such data in a single API specification.**

In addition, CMS proposes to include provider directory data in the open API requirements. While we are supportive of improving access to and the accuracy of provider directory data, we note that the current provider directory standards were written for FHIR version 3 and that the standard has not been adopted by the field. The health care field has indicated that they will not be adopting FHIR version 3 since it is not backwards compatible. Currently, vendors are either using FHIR version 2 or version 4, and ONC has proposed to use version 2. We believe that before CMS requires plans to make provider directory available via an open API more work would be needed to build the provider directory specification in FHIR version 4. Without a consistent standard across plans, app developers would have to rebuild their tools multiple times to work with the various proprietary APIs. This would ultimately prevent the type of innovation for consumer facing apps that CMS hopes to encourage.

Finally, we remain concerned about the privacy and security of a patient's health information when entered into a third-party application. While patients should have access to their health information, including the right to use the information as they see fit, it is unclear whether patients understand the ramifications of their actions when sharing their data with third-party vendors. Once shared, their data can be shared with other actors or used to generate advertisements. It also may be at risk for being further exposed, as third-party vendors are not required to encrypt patient's data, leaving the data vulnerable to hacking. We continue to encourage the agency to promote the safety and security of these data at every measure.

ADVANCING INTEROPERABILITY IN INNOVATIVE MODELS

CMS includes in this rule a request for comment on principles and ideas related to its intent to use the Center for Medicare and Medicaid Innovation (CMMI) authority to test ways to promote interoperability across the health care spectrum. Specifically, CMS seeks comment on general principles around integrating interoperability into new CMMI models and other ways CMMI could further promote interoperability among model participants.

One general principle CMS proposes is to promote trusted health information exchange by, in part, requiring model participants to participate in electronic alerting, through which EHR systems exchange notifications of a patient's admission, discharge and transfer to another facility or community provider. **We strongly urge CMS not to make electronic alerting a CoP in CMMI models, just as it should not be a CoP for providers to participate in Medicare.**

Thank you for your consideration of these comments. Please contact me if you have questions, or have a member of your team contact Nancy Foster, vice president of quality and patient safety policy, at nfoster@aha.org, or Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President