June 3, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Service
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Don Rucker, M.D.
National Coordinator for Health Information Technology
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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Dear Administrator Verma and Dr. Rucker:

The American Medical Rehabilitation Providers Association (AMRPA) is pleased to offer our comments on the Centers for Medicare & Medicaid Services’ (CMS) 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,” and the Office of the National Coordinator for Health Information Technology’s (ONC) rule, “21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program.”

AMRPA is the national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (referred to here as IRH/Us, but referred to by HHS as “IRFs”), outpatient rehabilitation service providers, long-term care hospitals (LTCHs), and several skilled nursing facilities (SNFs). Inpatient rehabilitation hospitals and units (IRH/Us) provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital post-acute settings. In 2018, IRH/Us served 340,000 Medicare beneficiaries with more than 380,000 IRH/U stays.1 AMRPA members help patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement.

1 Medicare Payment Advisory Commission, Executive Summary, Report to the Congress, Medicare Payment Policy (Mar. 2019).
Introduction
As post-acute care (PAC) hospitals, AMRPA members are in a unique position to appreciate the importance of interoperability of health information and the benefits to be realized from the free flow of medical information from one provider to the next in the continuum of care. The vast majority of patients receiving care in an IRH/U are transferred directly from an acute-care hospital. These patients have complex medical conditions and will receive an individualized and intensive course of treatment during their stay at the IRH/U. Having an effective and efficient way to receive and access the patient’s medical records can vastly improve care coordination and create important efficiencies for both the acute-care hospital and IRH/U. Further, most patients continue intensive treatment upon discharge from the IRH/U. Maintaining high quality and durable patient outcomes depends in part on the ability to communicate with downstream providers as patients continue their recovery. Due to IRH/Us’ position in the continuum of care that requires communication with both upstream and downstream providers, AMRPA particularly appreciates HHS’ continued efforts to move the U.S. health care system towards becoming more integrated.

Despite recognizing the importance of interoperability amongst providers, achieving interoperability between IRH/Us and other providers has been challenging. First and foremost, implementation of and updates to electronic health record (EHR) systems are resource-intensive and time-consuming. Much to the disappointment of IRH/Us, they, along with other PAC providers, were not eligible for funding through the Medicare and Medicaid EHR Incentive Programs under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

As AMRPA discusses further below, it would be fundamentally unfair at present to place the same requirements on PAC providers that are required of other providers, the latter of which have received tens of millions of dollars in incentive payments to establish EHR systems. According to HHS’ own research, PAC providers lag behind their acute-care counterparts (who did qualify for such funding) when it comes to the adoption of EHR systems due in part to this exclusion.² HHS Secretary Alex Azar acknowledged this disparity in a June 5, 2018 speech to PAC providers, stating that “the federal government has not always paid the same level of attention to advancing electronic health records in your industry as in traditional healthcare settings.”³

Due to this lack of funding from the federal government, some freestanding inpatient rehabilitation hospitals continue to lack EHRs. Others have invested significant resources adopting EHRs only to find that their health information exchanges are not interoperable with those of other providers, including acute-care hospitals within their own zip code. As AMRPA forewarned HHS during implementation of the Meaningful Use initiative, different care settings have developed different and incompatible EHR systems. As such, AMRPA supports a series of reforms to address these interoperability challenges in the PAC setting, which we outline below.

² Dougherty, M. Long-Term And Post-Acute Care Providers Engaged In Health Information Exchange: Final Report to the HHS Office of the Assistant Secretary for Planning and Evaluation. October 29, 2013.
I. **Revisions to the Conditions of Participation for Hospitals and Critical Access Hospitals (CAHs)**

CMS proposes to amend the Medicare hospital Conditions of Participation (CoPs) to require hospitals to send electronic patient event notifications (EPEN) to other providers with a relevant and established care relationship with the patient in question. CMS proposes that hospitals utilize changes in the admission, discharge and transfer (ADT) status feature in existing EHR systems to trigger a notification. CMS states this new requirement will only apply to hospitals that currently possess EHR systems with the “technical capacity” to generate information for EPENs. As outlined below, this proposal is premature, lacks sufficient clarity, and will therefore impose undue burden on hospitals with questionable benefit to patients.

A. **CMS’ Proposal to Amend the CoPs is Premature**

In response to CMS’ Request for Information (RFI) last year on enhancing interoperability, AMRPA detailed its concerns regarding CMS’ consideration of amending the CoPs to encourage interoperability. AMRPA noted in its letter that a CoP essentially serves as the harshest enforcement mechanism of all – potentially rendering a provider unable to participate in the Medicare program. Therefore, there are several interim but significant efforts that should be undertaken by CMS, HHS and the health care industry at large to improve interoperability before CMS amends the CoPs to compel hospitals to take burdensome steps to enhance their EHR.

Given that IRH/Us were not eligible for Meaningful Use (now Promoting Interoperability) program funds, there is an important subset of hospitals (and of the PAC continuum at-large) that have not yet been financially incentivized to adopt interoperable EHR. Even though acute-care hospitals have been incentivized to adopt EHR, interoperability is most useful when the entire care continuum is capable of receiving and passing along patient information. This allows a clear stream of information to flow with a patient as they transition from a hospital to PAC and beyond. Therefore, and as discussed more thoroughly in the next section, there should be additional funding opportunities for EHR adoption in PAC settings before CMS implements burdensome changes to the CoPs.

In addition to addressing interoperability for downstream providers, efforts also need to be taken to address patient matching difficulties among providers. As CMS is aware, there is not currently a national Unique Patient Identifier (UPI), as Congress has restricted HHS’ ability to develop such a program. This places significant barriers on providers’ ability to fully utilize transferred health information, even when using interoperable systems. Without the ability to confidentially match transferred data to a patient, the receiving providers rarely incorporate the information being transmitted into a patient’s medical record. This means that even if CMS requires hospitals to generate EPENs, the information may be of little utility to providers who currently lack the ability to confidently match the transmitted information to the correct patient. Therefore, until EPENs can be of more effective use to providers, CMS should refrain from implementing such a far-reaching requirement.

B. **CMS’ Proposed CoP Requirements Lack Sufficient Clarity**

CMS’ proposal to amend the CoPs to require EPENs lacks sufficient clarity and will create additional and unnecessary burden for providers. Based on our review of the proposed rule, it is unclear to which hospitals these requirements will apply, what steps hospitals must take to comply with the rule, and what technical specifications the patient event notifications must meet.
1. **CMS Should Clarify Which Hospitals Will be Subject to the New CoP**

In the proposed rule, CMS states it will only impose the EPEN requirement on hospitals “which currently possess EHR systems with the technical capacity” to generate EPENs. AMRPA is gravely concerned that this distinction lacks sufficient clarity and could lead to confusion and serious administrative burden on facilities. The proposed rule does not indicate where the line is drawn between systems that currently possess or lack the technical capacity to create such notifications. Given each provider’s unique circumstances, the resources required to add this capability could be minor, very extensive, or something in between. Since CMS has not expanded upon where exactly this line will be draw, it is unclear which providers this requirement will ultimately apply.

If implemented, CMS should specifically address how it will determine whether a hospital’s current EHR qualifies as being “currently capable,” and clarify the expenditures a hospital will be required to incur to activate this feature. CMS should be aware that even those hospitals eventually deemed not required to comply will need to undergo a burdensome examination of their system to determine whether they are subject to the requirement, or presume they are eligible and expend vast resources to bring their systems into compliance. As proposed, CMS may force hospitals to expend vast resources to determine their compliance with and/or satisfy this new CoP. Rather than imposing this burden on hospitals, we urge CMS to take the more gradual and less disruptive step of requiring hospitals that issue EPENs to continue doing so, and to work with the IRH/U industry as CMS seeks to expand the use of EPENs among other providers.

Finally, CMS relies heavily in this proposal on the ADT function, which is an HL7 feature. However, many direct message functions operate outside of the HL7 realm. AMRPA members seek clarity as to whether they must use HL7 integration functions to send notifications or whether they can use other methods. Our member hospitals believe that requiring HL7 integration of all providers would be an almost impossibly burdensome task, and AMRPA therefore urges CMS to clarify that hospitals may generate notifications via other means.

2. **CMS Should Provide Flexibility in Complying with this CoP**

In addition to the lack of clarity regarding which hospitals will be subject to the CoP, CMS is unclear as to how much flexibility providers will have in how they utilize EPENs. CMS states in the proposed rule that it expects providers would use ADT status changes to trigger notification. However, our member hospitals report that in many instances there may be a more effective way of communicating patient events to other providers. For example, some providers find that the ADT notification is triggered too early, often immediately upon discharge or transfer, which is before a discharge summary or other information can be compiled about the patient. Some providers may prefer the EPEN be triggered by another event, such as completion of the patient discharge summary. Otherwise, the notification may include minimal information for the downstream providers. CMS should clarify whether providers can use other triggers besides ADT to create patient event notifications.

AMRPA recommends CMS withdraw this proposal, or at the very least provide extensive clarification as to how this CoP implementation will limit potential burden on hospitals. Absent
that, and given the draconian consequence of not meeting the requirements of a CoP, hospitals will be compelled to take resource-intensive steps to ensure they can comply with this proposed requirement. Further, given the significantly more helpful information offered by events outside of ADT notification (for example, the completion of the patient discharge summary), we think it would be helpful if CMS first engaged with stakeholders to determine the best ways to collect this data prior to moving forward with implementation. Finally, and even if CMS proceeds without modification, this change will have little immediate positive effect given the lack of interoperability across the care continuum. Therefore, the burden of this proposal far outweighs the benefits and should be seriously reconsidered.

II. Provider Digital Contact Information (NPPES Database)
CMS proposes to increase the number of providers (both individuals and facilities) with digital contact information in the National Plan and Provider Enumeration System (NPPES) by publicly reporting the names and National Provider Identifiers (NPIs) of those providers who have not input their digital contact information in the NPPES. CMS proposes to begin public reporting in the second half of 2020.

In this proposed rule, CMS notes that it previously finalized a policy, in the 2015 Meaningful Use final rule, to use the NPPES to collect digital contact information from participants in the EHR Incentive Program. In other words, participants that received EHR Incentive funding have had four years to input their digital contact information in NPPES and meet the requirements of this proposal. As CMS is aware, IRH/U's were not included in the EHR Incentive Program nor in its related policies. AMRPA recommends CMS clarify in the final rule that providers who did not participate in Meaningful Use – such as IRH/U's and their employed clinicians – would be exempt from being publicly reported as proposed. This public listing should be based on the clarification of the rule determining what hospitals have EHRs with EPENs or direct messaging capabilities, as we have described above. As hospitals implement these EHR functionalities, then they would qualify for publicly being listed for non-compliance. However, it is unfair for CMS to expect all providers to meet the same compliance standard in 2020 when some providers have had multiple years to comply with this requirement.

III. Information Blocking Proposals
As previously discussed, IRH/U's are in a unique position in the continuum of care, often needing to receive crucial health information from upstream providers and also needing to pass health information downstream as a patient continues treatment after discharge from an IRH/U. Therefore, AMRPA is supportive of CMS and ONC’s efforts to limit information blocking practices.

A. Attestation and Public Reporting of Hospitals and Providers Information Blocking Practices
CMS proposes to report hospitals and providers that fail to attest that they do not engage in information blocking practices as part of the Promoting Interoperability (PI) and Quality Payment Program (QPP). While AMRPA does not support the more extreme step of amending the CoPs, we find that adding requirements to incentive programs such as the Promoting Interoperability and QPP programs is an appropriate incremental step towards interoperability. While this could deprive some hospitals of additional funding or business, we believe this is a more appropriate consequence at this still-early stage of interoperability, as opposed to total exclusion from the Medicare program. Therefore, AMRPA encourages CMS to finalize its
proposal to publicly report hospitals and providers that fail to attest that they do not engage in information blocking practices.

B. Prohibition on Information Blocking by Health IT Developers
ONC proposes to require as a Condition of Certification for health information technology (HIT) developers that they refrain engaging in information blocking practices, and that developers must provide assurances to ONC that they do not engage in such practices. As AMRPA stated in response to last year’s RFI, our hospitals are supportive of HHS taking steps within the realm of incentive programs to enhance interoperability. This would include ensuring that providers participating in the PI and QPP program, as well as the vendors supplying the systems, are not participating in information blocking practices. This is an incremental step that will not overly burden providers or vendors, while also enhance the overall availability of interoperable HIT systems. Therefore, AMRPA encourages ONC to finalize this proposal.

IV. Inclusion of Price Information within Electronic Health Information
ONC proposes to include elements of pricing within electronic health information (EHI). The agency posits that including price information within electronic health information will increase price transparency, allowing consumers to make more informed choices and ultimately bring down costs. However, AMRPA thinks this proposal will be overly burdensome and add little in terms of useful information for consumers.

Similar to AMRPA’s response to CMS’ proposal to require posting of hospital standard charges, AMRPA continues to believe that standard prices or negotiated prices between providers and insurers is of limited use to consumers. As HHS knows, the price to consumers for any given service is dependent on the interplay between the insurer’s cost-sharing policies, the provider’s price, and the consumer’s unique situation relative to deductibles and other utilization. Therefore, including a list price, a negotiated price, a price relative to the Medicare rate, or other price information, is of little use to the consumer in knowing their net cost.

While this data provides minimal benefit to consumers, providing this information will be burdensome on providers, particularly for hospitals that provide specialized care like IRH/Us. Given the unique needs of medical rehabilitation patients, it is not unusual for an IRH/U to negotiate rates on a patient-by-patient basis. While all providers would be burdened with entering standard rate information, the burden would be even higher for specialty providers to include specially negotiated rates in EHI.

Ultimately, it is payors, and not providers, that hold the keys to the information needed to inform consumers about their cost. Payors have the information on all three aspects needed to make that determination – the covered rate for the services, the cost-sharing responsibilities under the insurer’s policy, and the current utilization of the patient relative to deductibles and other fluctuating cost-sharing arrangements. Therefore, ONC should focus on bolstering insurers’ obligations to provide cost and price information, rather than providers.
If ONC were to finalize this proposal, it would have a ripple effect of administrative burden on providers, with little benefit to consumers. The proposed rule defines EHI in a very broad manner. If price information must be contained in all of these constructions of EHI, hospitals will be overwhelmed with the number of places it would need to insert this information. Further, as explained above, even if ONC more carefully tailors its requirement, the burden of providing this
information would provide little useful information to consumers. Therefore, **AMRPA recommends ONC not finalize its proposal to include some element of price information within the definition of EHI.**

V. Request for Information on Advancing Interoperability Across the Care Continuum

A. Incentivizing Adoption

As CMS recognizes, PAC providers have not had the access to federal funding to adopt HIT that other providers have had. AMRPA appreciates CMS’ recognition of this disparity and its request for feedback on ways to incentivize HIT adoption. **AMRPA recommends that CMS (and if needed, Congress) adopt or provide incentives to support EHR adoption in PAC and other settings excluded from Meaningful Use.** As a potential approach, CMS should consider a bonus payment framework that rewards PAC providers for achieving EHR adoption and demonstrating interoperable information exchange. This policy would not exclude PAC providers who have already dedicated considerable financial resources to integrating and adopting EHRs in their institutions. **Critically, any policy or initiative CMS implements to incentivize adoption must not come at a cost to PAC providers.** In other words, any incentive dollars made available to PAC must not be achieved through a “budget neutral” mechanism that depletes PAC funding from elsewhere in the Medicare program. Needless to say, it would further put PAC providers at an unfair disadvantage if PAC-specific EHR incentive payments were funded by reducing PAC funding elsewhere when no such budget neutral mechanisms were applied to acute-care providers that received funds under the Meaningful Use incentive program.

The Meaningful Use program has been in place for nearly a decade and, despite progress, interoperability among acute care and ambulatory settings is still not reality. Accordingly, **AMRPA recommends PAC providers be afforded an adequate ramp-up period or “glide-path” before they can be held to the same interoperability standards as acute care or ambulatory settings.**

B. Standardized Patient Assessment Data Elements (SPADEs)

CMS seeks input on whether acute care hospitals and physicians should adopt the capability to collect and electronically exchange a subset of the PAC standardized patient assessment data elements (SPADEs), such as functional status or pressure ulcers/injuries.

AMRPA has long supported enhancing the collection of patients’ functional status information and functional outcomes across the spectrum of providers and across the Medicare program through measures that are setting-appropriate. Achieving and maintaining functional ability is a critically valuable outcome to patients. While AMRPA fully appreciates CMS’ efforts to expand the collection of functional status data, **we are concerned about the agency’s suggested approach to utilize the SPADEs – which were developed for and validated in PAC settings – in non-PAC settings such as acute care hospitals and physician offices.** We encourage CMS to reconsider any “plug-and-play” approach and instead develop an appropriate method for adopting PAC SPADEs in other, non-PAC settings. **AMRPA recommends CMS convene a technical expert panel (TEP) as a first course of action to explore these issues.** Furthermore, we caution the agency against considering the SPADEs as any form of “gold standard” patient assessment items, despite their current usage across multiple PAC settings. **AMRPA**
encourages CMS to continue identifying or developing assessment items that are minimally burdensome and clinically appropriate for the care setting in which they will be used.

Even in PAC settings, collecting standardized patient assessment data is a relatively recent development, and CMS and stakeholders continue to work diligently on the implementation of SPADEs in order to collect data in a standardized manner. These efforts have entailed extensive provider education and training resources from CMS and from PAC providers to ensure that patients are being assessed consistently and accurately across settings; short of that, the collected data would not be truly standardized and therefore be of questionable utility or value. CMS would need to ensure that non-PAC settings/providers undergo comparable education and training to ensure uniformity and cross-setting consistency in the collection of SPADEs. There are also other technical issues CMS must be cognizant of as it considers integrating SPADEs in other care settings. For instance, PAC providers currently collect SPADEs over a multi-day lookback period consistent with CMS guidance for PAC patient assessments, but this practice would not be feasible in acute-care hospital and ambulatory settings in which patients have shorter lengths of stay. These factors collectively make AMRPA concerned about CMS’ proposal and we recommend the agency reconsider implementation at this time.

C. Measure Gaps and Development
AMRPA supports CMS’ work to develop consensus around measure concepts that could inform any evaluation of providers’ engagement in information exchange across settings, as well as the effectiveness of that engagement. As CMS recognizes, the measurement of interoperability has largely focused on the use of certified technology and the percentage of information exchanged. This domain will continue to be relevant if efforts are being made to enhance EHR adoption and exchange capabilities to care settings, such as PAC, that previously were excluded from Meaningful Use funding.

We note that CMS already intends to collect information on PAC providers’ use of electronic patient information transfer via new mandatory quality measures, pursuant to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. While AMRPA remains supportive of the agency’s efforts to assess interoperability and identify measure gaps, we oppose the use of mandatory PAC quality reporting programs as the data collection vehicles for this work. This approach unnecessarily adds burden to IRH/Us when valuable clinician time and attention should be dedicated to addressing the needs of patients. CMS should utilize other avenues to research and otherwise inform its understanding of interoperability issues.

VI. Request for Information on Advancing Interoperability in Innovation Models
As part of this proposed rule, the CMS Innovation Center (CMMI) seeks public comment on the principles for promoting interoperability as it considers interoperability requirements for all CMMI models going forward. AMRPA recognizes that CMMI models represent an important potential opportunity to advance progress toward interoperability. However, AMRPA does not support CMMI using innovation models as a “lever” for advancing interoperability, as CMS states in

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4 In the proposed FY 2020 Medicare payment rules for the IRF Prospective Payment System (IRF PPS) Skilled Nursing Facility PPS, and Long-Term Care Hospital PPS, CMS proposes to add two Transfer of Health Information measures to the settings’ respective Quality Reporting Programs.
the rule. There is a high degree of variability in EHR adoption across care settings due to the lack of incentive funding for all care settings. AMRPA is concerned that any move to make interoperability a prerequisite for CMMI model participation would only further exacerbate the existing disparities in EHR adoption and disadvantage those providers and settings (PAC, behavioral health, and community-based services, rural providers) that are already at a disadvantage vis-à-vis achieving interoperability. **CMS should strive to use CMMI funding as a means of supporting and enabling interoperability across the health care continuum and not use interoperability as a barrier of access to innovation funding.**

VII. **API Access to Beneficiary Data and Published Provider Directory Data**
AMRPA supports CMS’ proposal to require Medicare Advantage (MA), Medicaid, and exchange plans to make data on claims, treatment history, and plans’ provider directory data electronically available to beneficiaries through open application program interfaces (APIs). With regard to MA, **AMRPA further recommends that CMS provide MA enrollees improved access to information about MA plans’ utilization management strategies such as prior authorization requirements.** Prior authorization often has significantly negative impacts on patients’ access to medically necessary care which may also affect beneficiaries’ out-of-pocket costs.

Our member hospitals report that MA prior authorization systemically and detrimentally delays and denies patient access to IRH/U care. Even though MA beneficiaries are entitled to the same benefits as traditional Medicare beneficiaries, MA plans frequently utilize a unique and harmful prior authorization process based on proprietary guidelines for admission to IRH/Us. When Medicare beneficiaries are injured, become seriously ill, or require surgery, they often require medical rehabilitation in an IRH/U to regain functional losses. The majority of IRH/U patients are referred directly from acute-care hospitals, and hospitals strive to discharge patients as quickly as possible when the patient’s condition warrants. However, despite the vulnerable condition of IRH/U patients, even the most expeditious MA plans take one to three business days to respond to a prior authorization request for IRH/U admission. Unfortunately, the initial approval request is often just the first stage of the fight to admit MA beneficiaries to IRH/Us since a large majority of initial requests for IRH/U admission are typically, and often inappropriately, denied. This leaves acute-care hospitals in the precarious position of choosing between extending the stay of the patient (which may not be medically necessary) while an appeal is pursued, or discharging patients to lower-intensity PAC settings in order to open up availability of a hospital bed to accept new patients. Far too often, MA prior authorization leads to improper IRH/U service denials, referrals to less effective care settings that can compromise patient outcomes, and lengthy delays that cause irreversible harm to beneficiaries.

**As CMS strives to improve beneficiary access to their health plan data and enhance health plan transparency, CMS must take the necessary steps to educate beneficiaries about the potential negative consequences resulting from MA utilization management strategies such as prior authorization.**

**Conclusion**
AMRPA thanks the Administration for continuing to seek ways to improve interoperability and patient access to their health information, and we appreciate the opportunity to provide our comments. If you have any questions do not hesitate to reach out to Kate Beller, J.D., Executive Vice President for Policy Development and Government Relations of AMRPA (202-207-1132, kbeller@amrpa.org).
Sincerely,

Richard Kathrins, Ph.D.
Chair, AMRPA Board of Directors
President and CEO, Bacharach Institute for Rehabilitation

Mark J. Tarr
Chair, AMRPA Regulatory and Legislative Policy Committee
President and Chief Executive Officer, Encompass Health

Suzanne Kauserud, FACHE, MBA, PT
Chair, AMRPA Quality Committee
Vice President, Carolinas Rehabilitation – Atrium Health