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The Honorable Seema Verma
Administrator Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Room 445-G
Washington, DC 2020

Date: June 3, 2019

Subject: **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). 84 Fed Reg 7610 (March 4, 2019)**

Dear Administrator Verma:

Philips Healthcare (Philips) is pleased to have the opportunity to comment on the above-referenced Proposed Rule. Philips provides solutions that span the health continuum, including sleep management and respiratory solutions, imaging, patient monitoring, cardiac care systems; medical alert systems; healthcare informatics solutions and services; and a complete range of comprehensive telehealth programs.

Philips comments on the Proposed Rule focus on the proposal for patient access to their health information through Application Programming Interfaces (APIs); the exchange of health information and care coordination across payers; and care coordination through trusted exchange networks. Our comments also address the Proposed Rule's Request for Information about advancing interoperability in post-acute care (PAC) settings.

I. Philips and Interoperability

The Philips commitment to interoperability is historic and broad. Our Health Suite Digital Platform (HSDP) provides outbound exchange and external access to data, as well as convergence among FHIR and HL7 formats to provide an API-driven connected care ecosystem. Among our business units we hold membership in the CommonWell Health Alliance, certification and onboarding to the eHealth Exchange, and provide both automated push and query and retrieve exchange protocols. Philips also maintains membership within interoperability standards organizations including HL7, IHE, DICOM, IEEE and the Personal Connected Health Alliance. Our PHM platform business operates thousands of interfaces with vendors, labs and health systems to aggregate actionable data, yet must normalize approximately half of it into a common, readable format toward beneficial clinical usage and the creation of longitudinal records.

II. Comments

a. Patient Access to their Health Information through APIs

Philips supports patient access to health information held by MA Plans, Medicaid and CHIP Managed Care entities (MCOs, PIHPs, PAHPs), and QHP issuers in FFEs (Health Plans) and believes that such access is a central component of a patient-centered health care system. For this reason we believe that a provision requiring Health Plans to make this information accessible to patients should be included in the Final Rule.

In addition, it should be recognized that this information may be extremely helpful to health care providers in coordinating patient care, improving quality, and avoiding the provision of duplicative health services. We understand that, under the Proposed Rule, a patient's health information may be released to a third party (such as a provider) based on the patient's authorization; however, it is not entirely clear from the Proposed Rule how this authorization would be implemented. We urge CMS to require Health Plans to include in their enrollment processes an efficient "check off" authorization for an enrollee to authorize release of his or her health information to his or her provider(s), in order to facilitate care coordination and reduce

duplicative health services. Overall, patient consent should be leveraged to ensure that only those whom the patient expressly granted access to actually have access. Also, there should be means to record who actually accessed the patient information, what was accessed and when it was accessed.

b. **Health Information Exchange & Care Coordination Across Payers**

Philips supports CMS' proposal to require Health Plans to support electronic exchange of data for transitions of care, as patients move between plans. We believe that the electronic exchange of data accumulated by a Health Plan about diagnoses, procedures, tests, providers and utilization has the potential to facilitate more efficient care transitions. However, the extent to which Health Plans routinely access detailed clinical information is unclear to us: We are aware that health outcomes researchers generally believe that claims information alone is not sufficiently detailed to reach definitive conclusions about medical necessity. We would appreciate CMS' clarifying that the Proposed Rule imposes an obligation on Health Plans to convey all of the data —but only the data—that the Health Plan receives in the ordinary course of business. Specifically, we request that CMS clarify that Health Plans do not have an affirmative obligation to obtain from participating providers clinical information in addition to the information that the Health Plan receives in the ordinary course of claims submission: Imposing an affirmative obligation on a Health Plan to ensure the completeness of the clinical records it passes on to a successor plan has the potential to significantly increase administrative burdens on providers. Conversely, Health Plans should be required to include in the health data transmitted to successor plans the clinical data that the Originating Plan receives in course of prior authorization approval processes. In our view, any such data should be required to be included in Health Plan transition data sets, to avoid the need for duplicative PA requests.

c. **Care Coordination Through Trusted Exchange Networks**

Philips supports CMS' proposal to require Health Plans to participate in Trusted Exchange Networks that meet the specified requirements. Successful and collaborative networks and use

case development is in place through the organizations such as the CommonWell Health Alliance, Carequality and the eHealth Exchange. Participation in TEFCA as a voluntary program is already supported by vendors and Health Information Exchanges (HIEs) that participate in these networks. Even more widespread participation is anticipated: In February of this year, in the spirit of TEFCA's vision and goals, CommonWell announced its Connector's program, allowing any interoperability service provider to easily join/connect to its network without the normal membership and onboarding processes. And CommonWell and the eHealth Exchange already provide a directed query gateway between their networks. The current structure of the national exchange networks and increasingly streamlined onboarding will facilitate the participation of Health Plans, as proposed in the Proposed Rule.

We also believe that the widespread participation of Health Plans in HIEs will serve as a powerful incentive for providers to join HIEs, so that they can expeditiously communicate with the Health Plans regarding administrative and clinical issues. For example, it is our understanding that one of the most significant administrative burdens for health care providers is the submission of prior authorization requests and supporting clinical data. If providers are able to communicate electronically with Health Plans in processing PA requests, this has the potential to drive widespread participation of health providers in HIEs, without the need for regulatory mandates.

d. Hospital Admit, Discharge, Transfer

Many Philips customer hospitals systems already support ADT notifications, and we believe that expanded use of these notifications is an important aspect of care coordination and population health management. For this reason, Philips supports CMS' goal of expanding the use of admit, discharge, transfer (ADT) notifications among hospitals, and we specifically support provisions in the proposed rule that would require hospitals that have the functionality to provide ADT notifications to do so. At the same time, we appreciate CMS' sensitivity to the need to avoid disrupting existing workflows, and agree that the notification initially should be limited to the minimum data set.

Philips believes that CMS should support the use of push models of notification. As a member of the CommonWell Health Alliance, Philips worked successfully with the network to launch an automated events notification process that was demonstrated at this year's HIMSS conference. This notification process utilizes a push model of notification, which CMS should recognize as the preferred method of ADT. If a clinical application wanted to be sure that it had the latest information for the patient(s) and the full set of information, then query for the data would be a useful approach. This could be reserved for secondary access to the information sources so not to detract from the optimized workflow, but this query approach does serve a very useful role. We also believe the growth of automated ADT will benefit and motivate post-acute care systems to adopt interoperable health IT, and that expansion into ER settings has the potential to contribute to positive health outcomes. We do note, however, that the emphasis on ADT does not address the pathway into the inpatient setting; rather, system support for ADT focuses on the pathway out from the inpatient setting. Systems that support the ability of hospitals, physicians, and other health care providers to obtain a patient's full record (including patient generated data) upon initial and subsequent patient interaction, could lead to reduced time to diagnosis and treatment, especially for chronic conditions but also for trauma cases.

III. Request for Information regarding Interoperability in PAC Settings

We believe post-acute care is a vital aspect of population health management, readmissions reduction and healthcare system sustainability, and this area would benefit from expanded interoperable health IT. For this reason, Philips supports CMS' goal of examining incentives and other means to accelerate the adoption of interoperable health IT functionality in post-acute care settings. We note that basic EHR adoption among home health agencies (HHAs) and skilled nursing facilities (SNFs) is positive at 78% and 66% respectively, but that data exchange usage is low.

We suggest that, in order to advance interoperability in these settings it is important to adopt a clinically relevant and use-case driven focus that reflects the clinical needs of patients in PAC settings. It is also very important to consider the role of patient generated data in the PAC setting. In this setting, the usability of systems is especially critical. Care givers in PAC settings have very little time to use the technology so it needs to be highly efficient and not detract from their primary role of providing care to the patients.

In this respect we urge CMS to consider accelerating the adoption of interoperable health IT functionality by providing financial incentives for HHA adoption of remote patient monitoring (RPM) technologies. We are pleased that CMS has recognized the costs of remote patient monitoring in HHA cost reporting methodology and encourage the agency to accelerate the adoption of a mechanism for HHAs to obtain separate payment for remote monitoring services. Adoption of a mechanism for HHAs to obtain direct payment for remote patient monitoring would, we believe, spur adoption of RPM technology and care, thereby advancing the need for HHAs to exchange actionable patient data with acute and ambulatory systems and creating of sharable longitudinal patient records and other interoperability functions.

We also note that the Proposed Rule solicits comments on a proposal that would require hospitals to support ADT notifications as a condition of participation, and that the issuance of ADT notifications has the potential to incentivize PAC adoption of interoperable health IT systems. Overall, we support the routine electronic communication of ADT notifications as an important aspect of population health management and care coordination in PAC and other settings. As a member of the CommonWell Health Alliance, the Philips PHM business unit worked with CommonWell to successfully develop and demonstrate, at HIMSS, an automated/push model for ADT, and believe that push ADT, versus query and retrieve, has the potential to be of significant clinical and administrative utility to PAC settings.

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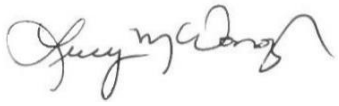
With respect to the inclusion of PAC data in the USCDI, we understand that CMS is engaged in an evaluation process of the Standardized Patient Assessment Data Elements (SPADEs) for post-acute care settings and that further analysis of reporting and other aspects of these data elements is underway through September of this year. Thus, while the inclusion of PAC setting data in the USCDI is especially important in light of CMS' proposal to require Health Plans to exchange USCDI data elements during care transitions, the timing is not ideal.

For this reason, Philips recommends that CMS finalize the current SPADEs examination process, and then propose PAC data elements for inclusion in the next iteration of the USCDI, under the process put forth in ONC's TEFCA proposed rule. In doing so, it is essential that the necessary data elements are clearly defined based on nomenclature and communication protocol standards. Regardless of whether and to what extent content requirements are phased in, it is essential that the data defined as "needed" is consistent across care settings. (For example, vital signs should be represented the same way across inpatient, home and PAC settings.)

We appreciate the opportunity to comment on these important issues. If you have any questions or if we can be any further assistance, please do not hesitate to contact me at Lucy.McDonough@Philips.com.

Sincerely yours,



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