

**STATEMENT OF**

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**ON**

**“IMPLEMENTING THE 21<sup>ST</sup> CENTURY CURES ACT: MAKING ELECTRONIC  
HEALTH INFORMATION AVAILABLE TO PATIENTS  
AND PROVIDERS (PART TWO)”**

**BEFORE THE**

**UNITED STATES SENATE COMMITTEE ON HEALTH, EDUCATION,  
LABOR & PENSIONS**

**MAY 7, 2019**

**Senate Committee on Health, Education, Labor & Pensions**  
**Hearing on “Implementing the 21<sup>st</sup> Century Cures Act: Making Electronic Health**  
**Information Available to Patients and Providers (Part Two)”**

**May 7, 2019**

Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss Centers for Medicare & Medicaid Services’ (CMS’s) efforts to foster innovation that promotes patient access to and use of their health information. We are committed to advancing interoperability and improving access to health information for patients in the U.S. health care system. As evidenced by our ongoing work, as well as our proposed rule now out for public comment, CMS is taking an active approach to move the health care market toward interoperability and the secure and timely exchange of health information by proposing policies for the Medicare and Medicaid programs, the Children’s Health Insurance Program (CHIP), and issuers of health plans sold on the Federal Exchange.

Last year, the Administration launched the MyHealthEData Initiative, which aims to break down the barriers that prevent patients from gaining electronic access to their health information from the device or application of their choice, empowering patients and taking a critical step toward interoperability and patient data exchange. As part of this initiative, we are taking a patient-centered approach to health information access and moving to a system in which empowered patients have immediate access to their health information electronically. Patients will have the ability to securely share their health information, creating a single record that will follow them as they move throughout the health care system, giving them the data they need to make the best decisions for themselves and their families.

**Medicare Blue Button 2.0**

In support of this goal, and in support of the MyHealthEData initiative, last year, the CMS announced the launch of Blue Button 2.0, our first secure, standards-based Application Program Interface (API) that allows Medicare beneficiaries to access and share their health care claims data with applications and services that help them manage their health, in addition to sharing this

information with their doctors and caregivers. API technology allows software from different developers to connect with one another and exchange electronic health information in electronic formats that can be more easily compiled and shared.

Through Blue Button 2.0, Medicare beneficiaries can select third party applications to connect to their data to compile and use their electronic health information. There are now 20 Blue Button apps available, which are posted on Medicare.gov, and developers are currently working on many more. Among other uses, these applications can help beneficiaries find plans, organize and share medical information and claims, or make appointments. We are also excited about the promises of research that can be enabled through beneficiaries choosing to share their data to help in the development of the next generation of cures and innovative treatments.

Ensuring the privacy and security of beneficiary data has been a priority for CMS since the beginning of this effort. We have taken a number of steps to protect beneficiary data, including regular systems security testing. Blue Button applications use existing CMS standards for beneficiary authorization, and they must use clear and plain language to alert beneficiaries to the sensitivity of the data they are sharing. Additionally, CMS offers a user-friendly dashboard on MyMedicare that allows beneficiaries to turn off data access for any application at any time.

### **Interoperability and Patient Access Proposed Rule**

Continuing to build on the MyHealthEData initiative, on March 4, 2019, CMS issued a proposed rule<sup>1</sup> on Interoperability and Patient Access that is intended to move the health care market toward interoperability. This proposed rule was inspired by, and demonstrates our commitment to, the vision set out in the 21<sup>st</sup> Century Cures Act and Executive Order 13813 to improve access to and the quality of information that Americans need to make informed health care decisions, including data about health care prices and outcomes while attempting to minimize the burden associated with these changes to plans, health care providers and payers.

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<sup>1</sup> Available at: <https://www.federalregister.gov/documents/2019/03/04/2019-02200/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and>

The proposed rule would enable patients to access their health information electronically by requiring the payers subject to this proposed rule to share health claims and other information electronically with their enrollees by 2020, much like CMS is already doing for Medicare beneficiaries through Blue Button 2.0. This empowers patients to take charge of and better manage their health care.

The rule also facilitates data exchange for health care providers and suppliers, including doctors and hospitals, to have access to health information about their patients, regardless of where the patient may have previously received care. Our proposals aim to connect providers through data exchange and provider directories while preventing them from engaging in the act of information blocking, or inappropriately restricting the flow of information to other health care providers and payers. These proposals support interoperable practices that may reduce the burden on health care providers.

CMS announced the rule concurrently with another proposed rule, issued by the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology (ONC). ONC's proposed rule updates the standards for certified EHR by identifying certain activities that ONC has determined are reasonable and necessary and making those activities exceptions to the original statutory definition of information blocking. Inspired by the 21<sup>st</sup> Century Cures Act, and in collaboration with ONC, the proposals in the CMS Interoperability and Patient Access proposed rule drive interoperability to promote competition and improve patient care.

#### *Patient Access through Application Programming Interfaces (APIs)*

A core policy principle underlying our proposals is that every American should be able, without special effort or advanced technical skills, to see, obtain, and use all electronically available information that is relevant to their health, care, and choices—of plans, providers, and specific treatment options. While many consumers today can often access their own health information through patient portals and proprietary applications made available by various providers and health plans, they typically must go through separate processes to obtain access to each system,

and often need to manually aggregate information that is delivered in various, non-standardized formats.

We are proposing to require that certain kinds of plans—Medicare Advantage plans, Medicaid fee-for-service and managed care plans, CHIP fee-for-service and managed care plans, and Qualified Health Plans on the Federal Exchange—maintain secure APIs that enrollees can use to access certain categories of their health data. This proposal would enable enrollees to use the application of their choice to access and use their own electronic health information. We hope that other payers might voluntarily offer this type of data accessibility so that even more patients across the American health care system can be empowered through easy access to their electronic health data.

#### *Health Information Exchange and Care Coordination across Payers*

As patients move throughout the healthcare system, in particular from health plan to health plan, they should be able to maintain access to their health information. Our proposed rule would require health plans to support patients in coordinating their own care through plan-to-plan health information exchange, electronic exchange of data as patients move between plans.

This proposed policy also leverages interoperability to facilitate care coordination among plans to reduce unnecessary care, as well as ensure that health care providers are able to spend their time providing care rather than performing unnecessary administrative tasks. For instance, effective information exchange between plans could improve care coordination by reducing the need for health care providers to write unneeded letters of medical necessity; by reducing instances of inappropriate step therapy; and by reducing repeated utilization reviews, risk screenings or assessments.

#### *Care Coordination through Trusted Exchange Networks*

We propose that Medicare Advantage organizations, Medicaid managed care plans, CHIP managed care entities, and issuers on the Federal Exchange be able to participate in a trusted exchange network, which would allow them to join any health information network they choose and be able to participate in nationwide exchange of data. Trusted exchange networks allow for

broader interoperability beyond one health system or point-to-point connection by facilitating secure exchange of electronic health information without special effort on the part of the user.

#### *API Access to Published Provider Directory Data*

We believe access to provider directories and network information is critical for helping patients get the care they need. Health plan provider directories help patients find in-network providers and allow healthcare professionals to locate other providers for purposes of referrals, transitions of care, and care coordination. To ensure that patients and providers have easy access to provider directory information, we propose to require Medicare Advantage organizations, state Medicaid and CHIP programs, Medicaid managed care plans, and CHIP managed care entities to make standardized information about their provider networks available to enrollees and prospective enrollees through API technology, much like the Qualified Health Plans on the Federal Exchange.

#### *Provider Digital Contact Information*

Provider contact information is critical to interoperability, care coordination and patient care. Last summer, to implement the requirements in the 21<sup>st</sup> Century Cures Act that required the Secretary to create a provider digital contact information index, CMS updated our online National Plan and Provider Enumeration System (NPPES) that maintains the National Provider Identifier (NPI) records for providers to collect this information and to allow providers to include one or more pieces of digital contact information that can be used to facilitate secure sharing of health information. Digital contact information, or electronic addresses for providers, allow them to exchange data faster and more efficiently while improving interoperability. Ultimately, we believe this technology could eliminate the need for fax machines in the clinical setting, but to make this technology effective, we need providers to make the most of it. To promote increased use of this provider digital contact information index, CMS is proposing to publicly report the names and National Provider Identifiers of those providers who have not added digital contact information to their entries in the NPPES system beginning in the second half of 2020.

### *Public Reporting of Information Blocking*

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a requirement that eligible clinicians and hospitals demonstrate that they have not knowingly and willfully taken action to limit or restrict the compatibility or interoperability of certified EHR technology.<sup>2</sup> CMS implemented these policies through attestation requirements in our Promoting Interoperability Programs.<sup>3</sup> We believe it would benefit the public, which includes patients and caregivers, to know if individual clinicians, hospitals, and critical access hospitals have submitted a “no” response to any of the three attestation statements regarding the prevention of information blocking. In our proposed rule, we propose including an indicator on the *Physician Compare* website for eligible clinicians participating in the Quality Payment Program, and to post information on a CMS website available to the public for eligible hospitals and critical access hospitals participating in the Medicare Promoting Interoperability Program, who submitted a “no” response to any of the three attestation statements regarding the prevention of information blocking.

### *Revisions to the Conditions of Participation for Hospitals and Critical Access Hospitals*

We have helped to facilitate data sharing and notification capabilities through our policies on provider directory information, and we further promote this by proposing to require that hospitals send electronic patient event notifications to other providers treating a patient when the patient is admitted, discharged or transferred from the hospital. Clinical event notifications are widely recognized as an effective tool for improving care coordination across settings, especially for patients at admission, discharge, and transfer.

We are proposing to revise the conditions of participation for hospitals and critical access hospitals to require that these entities send patient event notifications to other care providers or

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<sup>2</sup> Section 106(b)(2)(A) of MACRA amended section 1848(o)(2)(A)(ii) of the Act to require that an eligible professional must demonstrate that he or she has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology, as part of being a meaningful EHR user. Section 106(b)(2)(B) of MACRA made corresponding amendments to section 1886(n)(3)(A)(ii) of the Act for eligible hospitals and, by extension, under section 1814(l)(3) of the Act for CAHs. Sections 106(b)(2)(A) and (B) of MACRA provide that the manner of this demonstration is to be through a process specified by the Secretary, such as the use of an attestation.

<sup>3</sup> To review our discussion of these requirements, see the CY 2017 Quality Payment Program final rule (81 FR 77028 through 77035).

facilities that have an established care relationship with their patient. While deploying these notifications is low-cost and easy to achieve with any electronic health record system, many hospitals have not developed capabilities to send these notifications to other providers and facilities to whom they transition patients. We propose to limit this requirement to only those Medicare- and Medicaid-participating hospitals and CAHs that possess EHR systems with the technical capacity to generate information for electronic patient event notifications. This limitation will avoid burdening hospitals wishing to participate in the Medicare and Medicaid programs while still supporting efficient transitions of patient care whenever feasible.

*Request for Information: Advancing Interoperability across the Care Continuum*

Transitions across care settings have been characterized as common, complicated, costly, and potentially hazardous for individuals with complex health needs. Yet despite the need for functionality to support better care coordination, discharge planning, and timely transfer of essential health information, interoperability by certain health care providers such as long-term and post-acute care, behavioral health, and home- and community-based services continues to lag behind acute care providers. We are soliciting comment on several potential strategies for advancing interoperability across care settings to inform future rulemaking activity in this area. We are seeking solutions to more broadly incentivize the adoption of interoperable health IT systems and use of interoperable data across settings, such as long-term and post-acute care, behavioral health, and settings that serve individuals receiving home- and community-based services or who are dually eligible for Medicare and Medicaid.

*Advancing Interoperability in Innovative Models*

We believe that the Center for Medicare and Medicaid Innovation ("Innovation Center") models offer a unique opportunity to engage with healthcare providers in innovative ways and test new concepts and are an important lever to advance interoperability. CMS plans to promote interoperability across the healthcare spectrum through model testing that focuses on using emerging standards, models leveraging non-traditional data, and technology-enabled patient engagement platforms. The Innovation Center is seeking public comment on promoting interoperability among model participants and other healthcare providers as part of the design and testing of innovative payment and service delivery models.



### *Request for Information: Policies To Improve Patient Matching*

Finally, because patient identification is so critical to patient safety and information exchange, CMS is investigating ways to facilitate private sector work on a practical and scalable patient matching strategy. Together, CMS and ONC are requesting feedback on how we can leverage our respective authorities to improve patient identification, and thus patient safety, to encourage better coordination of care across different healthcare settings while advancing interoperability. We are also seeking comment on how we may leverage our program authority to provide support to those working to improve patient matching.

### **Promoting Interoperability**

Last year CMS announced an overhaul of the Medicare and Medicaid Electronic Health Record Incentive Programs (often known as the “meaningful use programs”) for hospitals after the Bipartisan Budget Act of 2018 increased our flexibility in implementing these programs.<sup>4</sup> We renamed these programs the “Promoting Interoperability Programs” to promote interoperability, help to maintain a focus on patients and reduce burden. With these changes, hospitals and critical access hospitals are subject to a new performance-based scoring methodology with fewer measures beginning in 2019, which moves away from the threshold-based methodology that was in place.<sup>5</sup> For clinicians, we changed the Merit-Based Incentive Payment System “Advancing Care Information” category to the “Promoting Interoperability” category by generally aligning with the revised requirements for hospitals by moving clinicians to a single, smaller set of objectives and measures.<sup>6</sup> We think these changes provide a less burdensome structure, allowing eligible hospitals, critical access hospitals, and clinicians to put their focus back on patients while still moving forward towards interoperability.

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<sup>4</sup> Bipartisan Budget Act of 2018 (Pub. L. 115-123), Section 50413, Reducing the Volume of Future EHR-Related Significant Hardship Requests, and section 51003, Technical Amendments to Public Law 114-10.

<sup>5</sup> 83 FR 41150

<sup>6</sup> 83 FR 59785

## **Moving Forward**

CMS is committed to creating a patient-centered health care system in which empowered patients have immediate access to their health information so they can better engage in and make decisions about their care. From our work with Blue Button 2.0 to the policies in the proposed rule, we want every stakeholder focused on the need for seamless data sharing so patients and providers can make decisions with complete, accurate sets of information and deliver the best health outcomes. Ultimately, we all need to work together to drive the seamless flow of information across the health care system. We are working toward a healthcare future when patients are able to obtain and share their health data securely and privately, with just a few clicks, and can ensure their care team is comprehensively informed of their specific care needs.