January 2, 2024

VIA Electronic Submission

Re: AHCA Response to: 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking Wednesday, November 1, 2023, 88 FR 74947; Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services (HHS). (RIN 0955–AA05)

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 15,000 long term and post-acute care facilities, or 1.07 million skilled nursing facility (SNF) beds and over 294,000 assisted living beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living (AL) communities as well as residences for individuals with intellectual and developmental disabilities (ID/DD).

We appreciate the opportunity to comment on the Information Blocking Disincentives Proposed Rule. SNFs serve a dual purpose. First, SNFs provide short-term post-acute services to patients who require skilled nursing and/or rehabilitation services on an inpatient basis. Second, SNF's/NFs furnish long-term care for residents requiring 24/7 care due to various medical, mobility, activities of daily living, cognition, and behavioral challenges that cannot be addressed adequately in the community.

Of note, and relevant to this proposed rule and associated request for information (RFI) is that, unlike other facility-based provider types, only slightly more than ten percent of SNF patient days are covered under the Medicare Part A, while nearly two-thirds are covered under Medicaid. Additionally, unlike hospital and most physician and professional providers, SNFs and other facility-based post-acute providers were excluded from the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 incentives intended to promote the adoption and meaningful use of health information technology (HIT).

In this comment letter AHCA would like to focus on the following key topics:

- **Proposed Rule Overview**
- **Medicare Shared Savings Program (88 FR 74962)**
- **Request for Information (88 FR 74966)**

1. Proposed Rule Overview

As defined by the Office of the National Coordinator for Health Information Technology (ONC), Information blocking is a practice by an "actor" that is likely to interfere with the access, exchange, or use of electronic health information (EHI), except as required by law or specified in an information blocking exception. The 21st Century Cures Act of 2016 applied the law to healthcare providers, health IT

developers of certified health IT, and health information exchanges (HIEs)/health information networks (HINs).

This proposed rule would implement the provision of the Cures Act specifying that a Medicare-enrolled health care provider (as defined in 45 CFR 171.102) determined by the HHS Inspector General (OIG) to have committed information blocking (as defined in 45 CFR 171.103) shall be referred to the appropriate agency to be subject to appropriate disincentives. Specifically, this rulemaking would establish for such health care providers a set of appropriate disincentives using authorities under applicable Federal law. The proposed rule also provides information related to OIG's investigation of claims of information blocking and referral of a health care provider to an appropriate agency to be subject to appropriate disincentives. Finally, the rule proposes to establish a process by which information would be shared with the public about health care providers that OIG determines have committed information blocking.

This proposed rule would not establish information blocking disincentives for all of the health care providers included in the 45 CFR 171.102 definition, but is limiting the application to those Medicare provider hospitals and critical access hospitals (CAH) that have been and remain eligible for receiving incentive payments for demonstrating meaningful use of EHR technology, and for most physician and professional providers under the Promoting Interoperability performance category of the Merit-based Incentive Payment System (MIPS). Additionally, this proposed rule would establish information blocking disincentives for Accountable Care Organizations (ACO) and providers/suppliers within an ACO as the ACO is eligible to obtain shared-savings incentive payments from the Medicare fee-for-service program.

The net impact of the disincentives of this proposed rule is to add other criteria to meet to obtain available incentive payments under the applicable incentive programs. In other words, if a provider is identified by the OIG to have committed information blocking, for at least one year, a hospital would not be eligible for the meaningful use incentive payment, a physician or professional provider would face negative MIPS program adjustments, and ACOs or providers within ACOs would lose eligibility to participate in an ACO.

AHCA Comment:

- **AHCA and our members recognize the significant benefits that the use of interoperable HIT would have on patient care and outcomes. However, historical financial and data specifications disparities have created a technology gap that needs to be addressed before SNFs should be subject to punitive information blocking policies.**

The foundation of interoperability is the use of standardized patient data elements (SPADES) and quality outcomes measures, and AHCA was a strong supporter of the enactment and implementation of the Improving Medicare Post-Acute Care Transformation Act (IMPACT ACT of 2014) that mandated the collection and reporting of standardized data in the following post-acute care settings: Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs). Successful implementation means that post-acute care (PAC) provider patient assessment information and quality measures are now aligned to improve communications and compare outcomes to a much greater extent than previously possible.

Despite being locked out of the massive amounts of HIT incentive payments available to hospitals and physicians/practitioners for more than the past decade, and the ongoing lack of interoperable HIT specifications that would be most useful to the day-to-day SNF workflows, SNF providers have been working with technology providers and various groups to reduce the technology gap. For example, supporting the recent CMS transition to the iQUIES system to submit patient assessment data for

Medicare Part A stays. However, significant barriers remain that prevent a majority of SNFs from exchanging HIT seamlessly with other providers or with beneficiaries. The ONC has recognized this and has thus created numerous exceptions to the requirement to fulfill requests to access, exchange, or use electronic health information (EHI). While our members appreciate the information blocking exceptions, this is not an ideal situation as the exceptions process adds its own burdens while not helping address the need to advance interoperable HIT capabilities among SNF providers. We believe that interoperable HIT standards applicable to SNF providers and some form of interoperable HIT incentive programs need to be available to support a SNF's investment in interoperable HIT before any information blocking disincentives be applied to SNF providers.

2. Medicare Shared Savings Program (88 FR 74962)

CMS proposes to revise the Shared Savings Program regulations to establish disincentives for health care providers, including ACOs, ACO participants, or ACO providers/suppliers, that engage in information blocking. Under this proposal, a health care provider that OIG determines has committed information blocking may not participate in the Shared Savings Program for a period of at least 1 year.

- First, CMS proposes to amend 42 CFR 425.208(b) to include a specific reference to the Cures Act information blocking provision codified in the PHSA.
- Second, CMS proposes to revise 42 CFR 425.305(a)(1) to specify that the program integrity history on which ACOs, ACO participants, and ACO providers/suppliers are reviewed during the Shared Savings Program application process and periodically thereafter includes, but is not limited to, a history of Medicare program exclusions or other sanctions, noncompliance with the requirements of the Shared Savings Program, or violations of laws specified at 42 CFR 425.208(b).
- Third, CMS proposes to make a conforming modification to the provision related to the grounds for CMS to terminate an ACO at 42 CFR 425.218(b)(3) to now be based on "[v]iolations of any applicable laws, rules, or regulations that are relevant to ACO operations, including, but not limited to, the laws specified at § 425.208(b)."

To operationalize these changes, CMS proposes to screen ACOs, ACO participants, and ACO providers/suppliers for an OIG determination of information blocking and deny the addition of such a health care provider to an ACO's participation list for the period of at least 1 year. In the case of an ACO that is a health care provider, CMS proposes to deny the ACO's application to participate in the Shared Savings Program for the period of at least 1 year. Reinstatement is possible upon evidence that indicated whether the issue had been corrected and appropriate safeguards had been put in place to prevent its reoccurrence.

CMS therefore proposes that, in cases where the result of the program integrity screening identifies that an ACO (acting as a health care provider), ACO participant, or ACO provider/supplier, has committed information blocking, as determined by OIG, CMS would take the following actions, as applicable:

- Pursuant to 42 CFR 425.118(b)(1)(iii), CMS would deny the request of the ACO to add an ACO participant to its ACO participant list on the basis of the results of the program integrity screening under 42 CFR 425.305(a).
- Pursuant to 42 CFR 425.116(a)(7) and (b)(7), CMS would notify an ACO currently participating in the Shared Savings Program if one of its ACO participants or ACO providers/suppliers is determined by OIG to have committed information blocking so that the ACO can take remedial

action—removing the ACO participant from the ACO participant list or the ACO provider/ supplier from the ACO provider/ supplier list—as required by the ACO participant agreement.

- Pursuant to 42 CFR 425.305(a)(2), CMS would deny an ACO's Shared Savings Program application if the results of a program integrity screening under 42 CFR 425.305(a)(1) reveal a history of program integrity issues or other sanctions and affiliations with individuals or entities that have a history of program integrity issues.
- Pursuant to 42 CFR 425.218(a) and (b)(3), CMS would terminate an ACO participation agreement in the case of a failure to comply with requirements of the Shared Savings Program, including violations of any applicable laws, rules, or regulations that are relevant to ACO operations, including, but not limited to, the laws specified at 42 CFR 425.208(b).

CMS proposes to apply the disincentive no sooner than the first performance year after the Agency receives a referral of an information blocking determination from OIG and in which the health care provider is to participate in the Shared Savings Program.

AHCA Comment:

- **AHCA recommends that CMS/ONC/HHS clarify in the final rule that these provisions, if finalized, do not impose any new information blocking regulatory requirements to individual ACO providers/suppliers beyond those promulgated under the ONC information blocking regulations.**

Since the enactment of the HITECH Act, SNF and other providers have been excluded from Federal health information technology (HIT) interoperability incentive programs, such as the current hospital meaningful use and physician and practitioner MIPS incentive programs that have supported provider investment in interoperable technology necessary to share information in a manner that would satisfactorily avoid information blocking regulatory noncompliance.

Additionally, there is currently a large gap in the information sharing standards between prior HITECH supported provider settings and post-acute providers such as SNF meaning that much of the information currently required under information blocking regulations cannot be shared in an interoperable manner by SNFs at this time. As such, the information blocking regulations used by the OIG to determine compliance include several exclusion criteria for such SNF providers.

We request that the Final Rule clarify that the information blocking requirements that apply to ACO providers/suppliers are specific to that provider's unique situation, and that the OIG would not apply a "one-size-fits-all" standard that applies to the most technology-advanced provider/supplier within the ACO, or the ACO itself.

- **AHCA recommends that a SNF provider be eligible for an exception from the information blocking exclusion if it is the only provider in a rural or underserved location and all other ACO participation requirements are otherwise met. This may include requirements for the ACO to help mitigate and overcome the identified information exchange challenges.**

We request that CMS/ONC/HHS consider the potential negative impacts on access to care in rural and underserved locations if the only SNF in a geographic region is excluded from participation solely due to the new technical information blocking requirement. While we estimate that this may only impact a small number of geographically isolated SNFs, we believe that such an exception policy is necessary to assure

that Medicare beneficiaries are not denied access to a nearby SNF to receive post-acute care solely due to a technical requirement if all other ACO care delivery and quality outcomes requirements are satisfied. The proposed policy, as currently described, would be more likely to discourage ACOs from participating in rural and underserved geographic areas which would be counterproductive to the desire to better coordinate care in these locations. Perhaps, in such situations, the ACO could be required to help the facility to overcome the interoperability barriers for a period of time to enable new providers with challenges to join the ACO, or to support providers already in the ACO but are having information blocking challenges to overcome those barriers.

- **AHCA recommends that a SNF or other ACO provider/supplier that is not explicitly identified in the ACO agreement as an incentive-sharing partner be exempt from the MSSP information blocking disincentive policy.**

One of the key principles of the MSSP program is for groups of providers to work together to provide better care with lower costs. Incentive payments are issued to ACOs that achieve these objectives via shared savings payments. ACOs and provider/supplier partners could use these shared savings to reinvest in clinical improvements and investments in health information technology to improve care. However, despite the use of the terminology *"shared savings"* in the incentive program name, there is no requirement for ACOs to share the incentive payments with providers in their network, which is one factor in why only a relatively small portion of SNFs participate in ACOs today. If CMS/ONC/HHS were to apply information blocking disincentive penalties to those SNF providers that do not have a meaningful opportunity to access incentive payments to reinvest in technology improvements and care processes, then it is likely that it will be even more difficult for ACOs to identify willing SNF provider partners. In the absence of a mandatory requirement for ACOs to include participating providers/suppliers in shared savings incentive payments, such providers should be excluded from the proposed disincentive policies.

We do not oppose the proposed information blocking disincentive policies for those ACO providers/suppliers explicitly eligible for ACO incentive payments in the ACO agreement if the OIG has found that their specific facility was capable of sharing specific requested information electronically but violated the information blocking regulations specific to their facility.

3. Request for Information (88 FR 74966)

CMS/ONC/HHS is requesting information from the public on additional appropriate disincentives that should be considered in future rulemaking, particularly disincentives that would apply to health care providers, as defined in 45 CFR 171.102, that are not implicated by the disincentives proposed in this rule. For SNF providers, this proposed rule, if finalized would only potentially impact SNFs participating in ACOs. The Agencies state a belief that *"…it is important for HHS to establish appropriate disincentives that would apply to all health care providers, as such providers are defined in 45 CFR 171.102. This would ensure that any health care provider, as defined in 45 CFR 171.102, that has engaged in information blocking would be subject to appropriate disincentives by an appropriate agency, consistent with the disincentives provision at PHSA section 3022(b)(2)(B)."*

AHCA Comment:

- **Given the current technology gap SNF providers face due to an absence of any meaningful support or incentives to adopt interoperable HIT that other provider types benefit from ands the current fragile state of the sector, we urge caution in adopting information blocking disincentive policies impacting SNF unless there are: 1) Clear interoperability**

specifications applicable to SNF resident needs for the OIG to base information blocking decisions on, and 2) The introduction of meaningful incentives to support the adoption of such interoperable technologies to which the information blocking requirement could be made a part of.

As noted above, the proposed new information blocking disincentives requirements in this proposed rule are directed at restricting existing provider incentive eligibility by adding a new achievement criterion. It does not impact the base provider Medicare fee-for-service payment models. As CMS/ONC/HHS consider how and when to introduce some form of information blocking disincentive policy requirements to SNF, we ask the agency caution until barriers to interoperable HIT adoption are addressed.

First, if CMS/ONC/HHS are to realize the ultimate objective to have all providers effective exchange health information electronically in a meaningful manner without the occurrence of information blocking, there must be clear interoperability specifications applicable to SNF to exchange information with other providers and beneficiaries for the OIG to base information blocking decisions on.

Second, as the nation recovers from the COVID-19 public health emergency (PHE), we remind CMS/ONC/HHS that SNFs and their residents were the hardest hit healthcare provider sector both clinically and financially. **In a recent MedPAC public meeting on December 7, 2023, the commissioners reported that the 2022 all-payer margin for SNFs across the country was a negative 1.4 percent**. This is not sustainable. While all other healthcare sectors have seen their workforce rebound after the PHE, per a recent Bureau of Labor Statistics report, SNFs now have nearly 150,000 fewer employees than there were at the start of the pandemic in early 2020, despite significant wage increases, resulting in SNFs being forced to limit occupancy.

Third, as mentioned in our comment letter preamble, we note that only slightly more than ten percent of SNF patient days are covered under Medicare Part A. Conversely, nearly two-thirds of SNF resident days are covered under Medicaid, which nationwide covers only about 80 percent of patient care costs. Any investment a SNF makes to upgrade interoperable HIT capabilities generally would apply to all payers and not just Medicare Part A patient admissions.

As a result, organic investment in advancing HIT across all SNFs without some form of incentive program is unrealistic until this situation resolves. Implementing one-sided punitive information blocking disincentive policies without first making investment incentives available as the sector restores its workforce will only worsen the situation.

Conclusion:

We are eager to work with CMS/ONC/HHS in identifying a pathway to overcome these challenges so that the Agencies can implement the information blocking disincentives statutory requirement most effectively while advancing HIT interoperability adoption across the sector. If you have questions about any of our comments, please contact Daniel Ciolek at dciolek@ahca.org.

Sincerely,

Daniel E Ciolek
Associate Vice President, Therapy Advocacy