September 24, 2018

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically via http://www.regulations.gov

RE: CMS-1695-P – Medicare Program; Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model

On behalf of OCHIN, we appreciate the opportunity to comment on the most recent Promoting Interoperability proposal. We applaud the Department’s efforts to improve interoperability, as it runs parallel to OCHIN’s goals and has a widespread impact on our national healthcare system.

OCHIN is a 501(c)(3) nonprofit community-based health information technology collaborative based in Portland, Oregon. OCHIN receives support from the U.S. Department of Health and Human Services through grants under the Health Resources and Services Administration (HRSA) and is a HRSA-designated Health Center-Controlled Network (HCCN). OCHIN’s mission is to pioneer the use of health information technology in caring for the medically underserved. As such, OCHIN serves community health centers (CHCs), including Federally Qualified Health Centers (FQHCs), rural and school-based health centers, safety-net providers and public health and corrections facilities across the nation. OCHIN’s comments are based on our experience as one of the largest health information and innovation networks in the US, serving hundreds of safety net organizations and over 10,000 clinicians nationwide.

OCHIN is a national network of ambulatory primary care providers connected through interoperability standards. We built our interoperability structure based on the need for continuous health information exchange that allows patients and providers timely access to electronic health records while ensuring security and protection of patients’ most valuable data. Interoperability began improving with the growth of electronic health records under Meaningful Use and the adoption of the 2015 Certified electronic health record technology (CEHRT), causing our focus to turn towards establishing connectivity for rural and underserved areas, improving data sharing, and reducing provider burden. It is through this unique lens that we offer our insight.
Our comments focus on a few overarching issues: continuing adoption of minimum 2015 standard CEHRT by all providers, including mental, dental, and behavioral health to enable interoperability; telehealth reimbursement; and reducing clinician burden.

OCHIN supports:

- A strong and robust safety net to ensure care for the most vulnerable population;
- Continued guidance from CMS to assist providers in the adoption of 2015 or newer CEHRT that can easily encourage data sharing;
- Utilizing virtual care and increasing reimbursement to meet identical rates to in-person services as well as waiving the face-to-face requirements for patient services; and
- Reducing provider burden by promoting the exchange of healthcare information through national framework’s standards, such as Carequality or Commonwell.
- Policies for CMS to continue to support adoption of national frameworks standards through incentive payments or other structures in order to encourage and assist providers not included in Meaningful Use to adopt minimum 2015 CEHRT.

OCHIN’s Comments on CMS’s Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange and the Meaningful Measures Initiative

- National Interoperability Framework: OCHIN believes the current national frameworks through systems such as Carequality and Commonwell will continue to work as they are adopted and gain maturity, especially sans state variability. Carequality as a method of data exchange is working nationally. As of August 28, 2018, Epic is reporting 3.5 million data exchanges on a daily basis. During the same time period, OCHIN exchanged 9,000 Continuity of Care Documents (CCDs) per day. As a leading national ambulatory health information network, OCHIN is a national use case that these frameworks work to exchange data efficiently and at very low cost. Full interoperability between all providers will provide cost reduction by improving care coordination as well as reducing administrative burden.

- Reduce Provider Burden: Align Medicaid and Medicare metrics. CMS should provide funding to increase provider participation in programs which support the safety net, especially for those not included in Meaningful Use, such as mental, dental, and behavioral health providers.

- Allow National Framework to Mature: OCHIN believes allowing national frameworks to mature as a “superhighway” of health information exchange is the best method. Due to individual market complexities, HIOs – although they have some value proposition to health information exchange – add costs and complexity to greater interoperability goals of national exchange. Furthermore, OCHIN urges caution regarding efforts to continue onboarding regional HIOs. HIOs result in dismal patient matching rates and requires unnecessary copies of patient records, creating compliance challenges. HIOs also require the payment of expensive annual membership fees.
• **Minimize Vendor Costs**: To reduce negative impacts on interoperability with changes in initiatives, programs, and measures, OCHIN suggests alignment of metrics across the board. When changes are required, CMS should seek input from health information technology vendors and outside stakeholders as well as providers when creating new measurements or changing current measurements. Misalignment in, or addition of measures create additional costs for health technology vendors, which are inevitably placed upon providers. For providers supporting those within the safety net, these additional costs can prevent a critical update to 2015 or better certified electronic health record systems. Lacking this upgrade hinders interoperability, exchange of data, and patient safety, disproportionately impacting the most vulnerable populations. OCHIN recognizes that moving from the 2014 Edition CEHRT to a 2015 Edition CEHRT may be onerous and challenging for providers that have not yet upgraded. To remedy this, OCHIN strongly suggests aligning Medicaid and Medicare metrics, as well as providing funding to safety net providers unable to meet the 2015 minimum CEHRT standards.

• **New condition for providers**: The vendor support of the national framework is evidenced by the rapid growth of this national framework by providers which has to date, more than 1,250 hospitals, 35,000 clinics, and 600,000 health care providers are connected, with these numbers increasing annually. However, as a Condition for Participation, OCHIN suggests creating a requirement to enable the national frameworks, such as Carequality and Commonwell, a capability of most 2015 Certified electronic health record systems to allow for national exchange of health information. This may require technical support which should be provided at no cost to participating providers. Having one of these national frameworks activated increases timely data transfer, improving quality of care and patient experience, while reducing provider burden and keeping patient data secure by reducing record duplications.

• **Use of Paper Copies**: If a provider cannot receive information electronically due to unreliability or unavailability as a result of insufficient infrastructure, CMS should consider partnering with other agencies to identify alternative funding streams to identify opportunities to bring these providers onto these systems. Those who never adopted electronic systems and continue to operate without electronic capabilities, their patients are in danger during any medical emergency or natural disaster. When Hurricane Katrina hit New Orleans, any providers in its path lost all of its medical records maintained on paper. This was devastating, and put many more people’s lives at risk. When Harvey hit Texas, lessons were learned from Katrina, and electronic records were safely stored out of the impact zone, easily available to emergency responders.

OCHIN’s Comments on Discrepancy with Burden-Alleviation Intention

• **Reducing provider burden for EPs using MIPS and MU**: In response to a comment replied to in CMS-1694-F which stated that “the 2015 Edition does not have the capability to meet the Modified Stage 2 meaningful use objectives and measures.” On the contrary, the 2015 Edition of CEHRT meets Modified Stage 2 meaningful use objectives and measures. OCHIN has had 2015
CEHRT in place since mid-2017 (Epic), which we have used to meet Stage 2 meaningful use objectives and measures.

We thank you for your time and consideration of our comments on CMS-1695-P. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll
VP, Government Affairs and Public Relations