November 19, 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-3346-P Medicare and Medicaid Programs: Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

OCHIN appreciates the opportunity to submit the following comments in response to the request to address regulatory provisions to promote efficiency, transparency, and burden reduction. We applaud CMS’s efforts as we believe provider and administrative burden is at an all-time high. OCHIN is patently aware of the consequences of this burden, and how overly complex electronic processes and input requirements can result in provider burnout or “click fatigue.”

OCHIN is a 501(c)(3) not for profit community-based health information technology (HIT) collaborative based in Portland, Oregon. OCHIN receives support from the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA), and is an HRSA-designated Health Center-Controlled Network (HCCN). OCHIN’s mission is to pioneer the use of health information technology (HIT) 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 correction facilities across the nation. OCHIN’s comments come through the lens of members we serve.

OCHIN Supports:

- Using MAT and other program funding to drive onboarding for behavioral health providers as outlined in the Nov. 13, 2018 Medicaid Director Letter;
- Encouraging healthcare payer and Medicaid to drive consistency in telehealth payer structure;
- Continued adoption of 2015 or newer Certified electronic health record technology (CEHRT) that can easily encourage and facilitate data sharing;
- Reducing provider burden by promoting the exchange of healthcare information through national framework’s standards, such as Carequality or Commonwell;
• Seamlessly integrating currently external capabilities into the EHR such as PDMP; and

• 42 CFR Part 2 reform to ensure needed data sharing and care coordination to address the opioid crisis.

OCHIN Comments on the Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

OCHIN urges CMS to continue to challenge providers and systems to enable national framework standards and reduce variation in health information exchange (HIE) standards thus increasing interoperability and reducing burden for administrators, providers, and developers. To further reduce provider burden, OCHIN suggests CMS focus on aligning metrics, incorporating reporting capabilities into the EHR, automation of testing and integrating third party devices, and seamlessly integrating all current third party web portals into the EHR, such as the PDMP. Ideally, providers will not have to leave their workflows in order to complete a patient visit and all requisite documentation.

I. National Frameworks Standards

The national frameworks standards OCHIN supports are exemplified in Commonwell, CareEverywhere, and Carequality, three of the frameworks used by OCHIN to exchange medical data across the United States and into some international territory. To onboard all providers to national frameworks standards, providers must be on 2015 or better certified electronic health record technology (CEHRT). Those in possession of 2015 and later EHRs can easily enable the national framework, reaching optimal interoperability with just a few clicks.

OCHIN believes the national HIE framework will overcome many issues associated with provider burden when paired with alignment of national standards. Requiring all healthcare providers to connect to a single national HIE framework would ensure all records are available upon confirmation of appointment, and the data will populate accurately in the proper fields. This national framework would similarly overcome the patient matching issue plagued by many local/regional HIE networks. The national frameworks possess patient matching algorithms which display high rates of success in comparison to regional alternatives. This process requires funding to increase HIE participation for those not included in Meaningful Use, such as mental, dental, and behavioral health providers.

Ideally, 2015 and greater EHRs which enable the national frameworks standards will incorporate reporting capabilities, so the simple click of a button can directly send all requisite information to the appropriate agency/agencies. This would further reduce provider and administrative burden, as there would be no scramble to gather the requisite statistics, it would already be internally available. There would also be no arduous submission process, it would instead be simple and painless, ensuring the technology relays all necessary information to fulfill reporting requirements.
II. Align Metrics, Reduce Flexibility

To reduce provider burden, all metrics - both state and federal - must be aligned. Without alignment of metrics, health records converted into the host EHR often result in data unmatched with a field, causing a large portion to transfer in plain text into the notes area. Providers must then transfer that data into the proper fields, which is not an effective use of their time. Avoid allowing state level individual metrics for specific programs. These variations prevent EHR developers from creating an embedded metrics reporting system. Instead, set national standards and ensure they are followed at the state level to simplify data transfer and reporting.

It is imperative that these metrics capture the sensitive work of federally qualified health centers and safety net clinics. Research into social risk factors has shown that complex patients supported by the safety net require more resources than those often covered by private insurance. OCHIN suggests CMS utilize an all-inclusive set of standards to continue to track the success of these HRSA-supported clinics and ensure these complexities in vulnerable patients are accounted for.

III. Integrate Third Party Web Portals

It is imperative that CMS focus on integrating external web portals. This would prevent providers from having to leave their normal workflow to import or export necessary data. Currently, most providers have to toggle from the EHR over to various other third-party web portals. Some examples of this purpose are fetching or sharing information into or out of a regional HIE, the state PDMP, or state immunization registries.

Every time providers must spend the time to change screens, enter login information, and then manually enter data from the web portal into the EHR, they are wasting time they could be spending conversing with or examining the patient. Much of this wasted time can be saved by integrating these portals into the EHR. If all providers are on 2015 or higher CEHRT, regional HIEs can be phased out. If all metrics are the same nationally, then EHR developers can work on integrating vital statistics and other important public health mechanisms into the EHR.

With the true integration of the PDMP into the EHR, providers won’t have to log into a state PDMP to check patient’s prescription history, and further, they would be able to easily perform interstate data sharing – a capability that often requires extra work and higher costs. The national HIE frameworks paired with an integrated prescription drug monitoring program (PDMP) prevents the need to toggle between multiple systems. However, it is also paramount that all PDMP capabilities are available on the EHR system. Certain options should not remain on the website, while most are in the integrated EHR. Ideally, state PDMPs could be phased out to be replaced with a national system, ensuring interstate queries are performed with every use, and that all capabilities are built in.

Interoperability allows providers and agencies to transmit data seamlessly, without time consuming requests or lengthy transfers. Bidirectional immunization records and vital statistics data feeds without the need to directly connect to a regional HIE also has the potential of reducing provider
burden by further streamlining workflows. With the availability of vaccinations at small locations such as Walgreens and CVS, it is critical that this information is transferred into the EHR to ensure the physician is aware of vaccines which have been administered. Vital statistics data help ensure records are kept up to date, and pulled with the incidence of a patient’s demise.

IV. Third Party Devices

Expanded automated testing, integration with third party devices (such as EKGs and vital devices) as well as incorporation of metadata through APIs are additional methods to reduce provider burden. These products can directly integrate data into the EHR to reduce burden and increase accuracy, bypassing human error. With the movement towards the national standards framework, more devices can be adapted to directly input data. With a national market, developers would increase investments in product development, inevitably leading to more integrated healthcare devices.

V. Workgroup

Prior to changing reporting requirements, OCHIN recommends creating working groups of EHR vendor associations and providers to collaborate in how the EHR could help clinics and providers meet reporting requirements without additional burden.

We appreciate your consideration of our comments. Please contact Jennifer Stoll at stollj@ochin.org should you have any questions.

Sincerely,

Jennifer Stoll
VP, Government Affairs and Public Relations