



33 W Monroe, Suite 1700  
Chicago, IL 60603  
[swillis@ehra.org](mailto:swillis@ehra.org)  
Phone: 312-915-9518  
Twitter: @EHRAssociation

- [AdvancedMD](#)
- [AllMeds](#)
- [Allscripts](#)
- [Aprima Medical Software](#)
- [BestNotes](#)
- [Bizmatic](#)
- [Cerner Corporation](#)
- [ChartLogic, A Division of](#)
- [Medsphere Systems](#)
- [CureMD Corporation](#)
- [eClinicalWorks, LLC](#)
- [eMDs](#)
- [EndoSoft](#)
- [Epic](#)
- [Evident](#)
- [Flatiron Health](#)
- [Foothold Technology](#)
- [Greenway Health](#)
- [Harris Healthcare Group](#)
- [Lumeris](#)
- [MacPractice](#)
- [MEDHOST](#)
- [MEDITECH](#)
- [Modernizing Medicine](#)
- [Netsmart](#)
- [Nextech](#)
- [NextGen Healthcare](#)
- [Office Practicum](#)
- [Sevocity, A Division of](#)
- [Conceptual Mindworks](#)
- [SRS Health](#)
- [STI Computer Services](#)
- [Vālant Medical Solutions](#)
- [Varian Medical Systems](#)
- [Virence Health](#)
- [Wellssoft Corporation](#)

June 3, 2019

Seema Verma  
Administrator, Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Administrator Verma,

On behalf of the more than 30 member companies of the Electronic Health Record Association (EHRA), we are pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) proposed rule on Interoperability and Patient Access. We appreciate this opportunity to provide input on CMS' proposal to advance interoperability and improve patient access to their health information.

EHRA members serve the vast majority of healthcare organizations that use electronic health records (EHRs) and other health information and technology (IT) to deliver high quality, efficient care to their patients. Established in 2004, EHRA operates on the premise that the rapid, widespread adoption of health IT has and will improve the quality of patient care as well as the productivity and sustainability of the healthcare system. We focus on collaborative efforts to accelerate adoption, enhance the usability of EHRs, advance interoperability, and improve healthcare outcomes through the use of these important technologies.

Our full comments follow this letter; briefly, our feedback includes:

**APIs:** EHR Association members support referencing the use of common standards for payer-payer exchange that are also to be used for provider-provider and provider-consumer exchanges, based on USCDI.

**Conditions of Participation:** EHR Association members support the intent of the proposal to improve interoperability and care coordination by revising Conditions of Participation (CoP) for Medicare- and Medicaid-participating hospitals, to require electronic notifications upon a patient's admission, discharge and/or transfer (ADT). We recommend expanding this information exchange requirement to include emergency departments. However, we note that any electronic ADT requirement

anticipates that the receiving facility or provider has the technological capabilities that, in fact, are not yet universally implemented.

**Care Continuum:** EHR Association members agree with CMS's assessment that post-acute, behavioral health, and Critical Access Hospital care settings have lagged in EHR adoption in comparison to Meaningful Use participants. While the proposed rule is oriented toward interoperability, the environments named in this request for information must first be digitized with modern, robust EHRs. Moving those care settings forward so they are using updated health IT, certified to the same interoperability standards as Eligible Physicians/Eligible Hospitals (EPs/EHs), will need to be step one to facilitate the exchange of data between these groups.

**Innovative Models:** EHR Association members strongly support efforts to enhance interoperability, and we agree that the Center for Medicare and Medicaid Innovation (CMMI) could play a useful role in efforts to promote interoperability. However, CMMI's interoperability efforts would be more effective if interoperability experts and technology experts are consulted early on, when their input can help shape upcoming programs. A more inclusive planning process will allow developers additional time to redesign and/or develop solutions that will enable greater program participation and ultimately greater success.

**Patient Matching:** In the absence of a national, unique identifier, best practices--in combination with evolving matching techniques, standardization of typical fields used in matching, and use of alternative unique identifiers--can produce substantial progress. EHR Association members strongly believe that a key component of accurate patient matching is the sharing of best practices on processes and education that demonstrates the need for healthcare organizations to invest in improving their registration processes.

The Association looks forward to continuing to work with CMS and other stakeholders toward expanded interoperability and enhanced patient access to their data. Please contact Sarah Willis-Garcia, EHRA Program Manager, at [swillis@ehra.org](mailto:swillis@ehra.org) or 312.915.9518 with questions or for more information.

Sincerely,



Cherie Holmes-Henry  
Chair, EHR Association  
NextGen Healthcare



Sasha TerMaat  
Vice Chair, EHR Association  
Epic

## HIMSS EHR Association Executive Committee



David J. Bucciferro  
Foothold Technology



Hans J. Buitendijk  
Cerner Corporation



Barbara Hobbs  
MEDITECH, Inc.



Rick Reeves, RPh  
Evident



Emily Richmond, MPH  
Allscripts/Practice Fusion



Courtney E. Tesvich, RN  
Nextech

### **About the EHR Association**

Established in 2004, the Electronic Health Record (EHR) Association is comprised of more than 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit [www.ehra.org](http://www.ehra.org).

## **Comments of the HIMSS Electronic Health Record Association on the proposed rule from the Centers for Medicare and Medicaid Services**

---

### **III. Patient Access Through APIs**

The EHR Association supports the proposal that payer-to-payer exchange use the same common standards being proposed for use in provider-to-provider and provider-to-consumer exchanges, specifically the requirement to support the United States Core Data for Interoperability (USCDI) standard. However, from our historical experience as health IT developers working with both payers and consumers, we believe that there is relevant data for payer-to-payer and payer-to-consumer exchange not fully recognized in the USCDI.

We believe that there are different use cases for various data types that are included in exchange, and that organizations should be able to support the data categories relevant to their customers and business. Thus, we recommend that CMS coordinate with ONC to include such data in USCDI, while at the same time working with ONC to be able to identify subsets of USCDI data categories so that it is easier for organizations to understand what data must be supported by organizations that facilitate payer-to-payer/consumer access and/or exchange versus the data required by organizations supporting provider-to-provider/consumer exchange. We believe that synchronizing the interoperability standards across these different use cases by building on a common USCDI will enhance the EHR's ability to more consistently share the same data across a variety of stakeholders.

Furthermore, we recognize that other stakeholders are just now starting to use FHIR APIs and acknowledge the potential time challenges they may face; for example, the time and effort to express data in a particular standard format differs greatly from that of aligning vocabularies where needed, as the same data will increasingly be shared and re-shared across stakeholders. Also, expanding participation in trust frameworks with payers can further assist in progressing consistent interoperability while reducing point-to-point agreements and technologies that providers would otherwise have to address.

### **X. Revisions to the Conditions of Participation for Hospitals and Critical Access Hospitals (CAHs)**

The EHR Association is supportive of the proposal to revise Conditions of Participation (CoP) for Medicare- and Medicaid-participating hospitals to require electronic notifications upon a patient's admission, discharge and/or transfer (ADT) to another healthcare facility or community provider. Event notifications will improve the ability of stakeholders to coordinate care through awareness of where the patient has been seen.

We recommend expanding the electronic notification requirement to include emergency departments (i.e. not just for inpatient hospital patients) as we have heard from our customers that these types of notifications would also be useful.

Any CoP requirement for Medicare- and Medicaid-participating hospitals to send electronic notifications of a patient's admission, discharge and/or transfer will require that healthcare organizations on the

receiving end of those notifications have the technology capabilities implemented. Based on our experience working with outpatient healthcare organizations, EHR Association members know that these capabilities are not universally implemented today. In order for the full benefit of these mandatory notifications to be felt, health IT developers that support healthcare organizations will need to do additional development work to receive these types of notifications. Additionally, healthcare organizations and providers will need to make modifications to their current workflow if that data is to be incorporated into and presented appropriately and usefully within the clinical record.

Also, we suggest that the focus of “patient event notifications” be cross-stakeholder notifications, rather than internal notifications within the health system. Most health systems do have capabilities to inform their staff. Focusing on external patient event notification can yield substantial value both for awareness and the ability to identify patient record locations.

Not all stakeholders will be part of a network that will make these types of notifications easier to implement, and organizations that are working to support both in-network and out-of-network notifications may require different technical capabilities for each use case. For example, out-of-network notifications may be best implemented using Direct. Therefore, we believe that solely referencing HL7 v2.5.1 ADT messages as the requirement is too restrictive. Furthermore, national-level implementation guidance to consistently bridge networks or support out-of-network connections are not yet available. At this stage, specifying any particular standard is premature, and we recommend that CMS, instead, take an approach similar to ONC’s initial rollout of consumer-focused APIs.

Lastly, we note that the existence of a “phone book” through which providers can connect to each other in a consistent and cost-effective way will be fundamental to success with this effort, as recognized in proposed rules from both CMS and ONC. The technical ability to identify information about who a provider is expected to notify--the end address where the notice needs sent--is not in place at this point. Even if providers have digital addresses--the NPPES requirements--patients frequently do not know this information, and it is not easily available. In addition, if the message to the provider fails for any reason, a mechanism would be needed to redirect the communication or to let the author of the communication know that the message did not reach the intended recipient.

As stated, we strongly support the basic concept of requiring electronic notification but a thoughtful iteration of the steps needed is important. To fully support these proposals, the Association requests additional clarification that would help our members to most efficiently implement and support the requirement, should it be finalized:

- EHR Association members request that CMS provide clarification on how a hospital’s participation would be measured if they choose to use an intermediary (e.g. a health information exchange) and do not have knowledge of whether a notification reaches a recipient.
- EHR Association members request that CMS provide clarification on what a hospital is expected to do when a patient does not have a primary care provider and there is not a known recipient of the notification at the time of admission, discharge, or transfer.

## **XI. Request for Information on Advancing Interoperability Across the Care Continuum**

The EHR Association applauds consideration of the Post-Acute, Behavioral Health, and Critical Access Hospital care settings, and how best to connect them to the larger healthcare system going forward. Increased electronic data capture; applying that data to opportunities like clinical decision support and registry reporting; and, improving care coordination with other stakeholders will result in positive returns for patients, caregivers, and public health entities.

Also, we agree with CMS' assessment that the areas of care that are mentioned have lagged in EHR adoption in comparison to Meaningful Use participants such as Eligible Providers (EPs) or Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs). Despite this support, it is clear that it is important to be mindful of the existing behavioral health regulations around exchanging patient data in order to ensure that this final rule does not result in conflicting regulations.

While this proposed rule is focused on interoperability, the environments named in this request for information must first be digitized with modern, robust electronic health records. Moving those care settings forward so they are using updated health IT, certified to the same interoperability standards as EPs/EHs, will need to be step one to facilitate exchange of data between these groups.

There are tools at the disposal of CMS and state entities interested in promoting increased adoption of robust EHRs within the post-acute and behavioral health spaces. For example, CMMI could launch programs under its authority to build the value proposition for greater adoption, such as bundled payment models with per patient/per month frameworks. Additionally, CMS, within its larger payment schemas revised annually, could include payment options similar to those offered to ambulatory providers that reward care coordination.

A critical component in all programs that encourage the adoption of health IT, as part of a larger value-based reimbursement or quality improvement program, is that the tools (screening tools, questionnaires, etc.) that are expected to be exchanged are codified in a standard format, as this is a fundamental requirement for enhanced interoperability.

It is possible that as standards become more prevalent for behavioral health screenings, assessments, etc., and their results, these components could be incorporated under the USCDI. As any data element is added to the USCDI, it should be evaluated for an appropriate timeline for incorporation. The timeline feasibility assessment should also consider other initiatives happening at the same time, to avoid overwhelming health IT developers and users.

EHR Association members have significant concerns about the feasibility of adopting and using the proposed data segmentation standards outlined in the proposed rule revising ONC 2015 Edition Certification. We do not see adoption of the complex proposal as feasible in the short term. To the extent that these interoperability initiatives interact with those proposed standards, that timeline is a critical factor that will need to be considered.

Regarding the applicability and feasibility of measure concepts for PAC, behavioral health, home and community-based services, the Association recommends looking at existing programs and attempting to align program requirements, where feasible, to reduce the burden on clients.

## **XII. Advancing Interoperability in Innovative Models**

The EHR Association strongly supports efforts to enhance interoperability, and we agree that CMMI could play a useful role in efforts to promote interoperability.

EHR developers, such as those companies that make up the membership of the EHR Association, have a vested stake in seeing the models of the CMMI succeed. We are committed to supporting the nation's best interests in helping identify better payment models that will better address the challenges of lowered costs and improved patient outcomes, and we devote extensive effort to supporting our clients in their participation. The models launched by the CMMI could be very advantageous to the healthcare industry, but any such model will need feedback and input from technology developers in the early stages of model development to inform feasibility regarding data capture, technology use, and timelines.

In recent years, we have not been included in conversations during the development phase of new or revised programs. Our feedback has been requested later, when it was too late for our input to be considered. In fact, we frequently must invest in development associated with new CMMI demonstration projects, including functionality and/or measures that are not already part of the CEHRT program. Instead, we urge CMMI program-development teams to consult experts from EHR developer companies as ideas are first being considered. A more inclusive planning process will allow developers the opportunity to provide input on the technical feasibility, as well as time to develop solutions that will enable greater program success, especially for models designed for settings that do not use certified EHRs, such as behavioral health and post-acute care.

Models that would involve projects such as piloting a new standard with the cooperation of participants' health IT developers should require early input on the model feasibility from developers. If this consultation and early feedback is not gathered, models may be launched that are not feasible for providers to participate in or that require unnecessarily burdensome or expensive changes to their health IT.

We appreciate the question about the incorporation of more social determinant data, such as that related to school, housing, and food insecurity. We believe this is an important area to explore, and we must all recognize that many of the ideas in this area would require extensive technological investment by the health IT development community, which would take time, and the digitization of information being captured in other relevant environments. Currently, it is not clear where to capture and display this information in an EHR, for example. This would be a topic on which we would be eager to engage with industry stakeholders to be mindful of usability implications.

We suggest that the industry think critically about which SDOH information would be most clinically valuable, how and when it could best be collected, and how to connect clinicians to other support

services in the region so as to allow them to actually act on the information when it is presented to them. It is certainly clear that standards are currently not well-articulated as to how best to effectively capture or transmit this type of information, which frequently comes from non-CEHRT sources.

Finally, we suggest that as CMMI models are being designed, interoperability capabilities should be recognized and addressed from the start. The ability to achieve the intended objectives increasingly depends on supporting systems sharing relevant data across stakeholders. Having insight into the existing ability to share such data can inform an optimized timeline and positively impact the opportunity for success.

### **XIII. Request for Information on Policies to Improve Patient Matching**

The EHR Association contributed input to the recent Government Accountability Office (GAO) report on patient matching, and we support the general suggestions to date to further normalize data such as addresses, while also focusing on finding agreement on emerging identifier,s such as cell phone numbers, and strong identifiers already in place. Experience has shown, however, that collecting these extra identifiers remains challenging, adding time to the registration process.

For example, in the case of the suggestion in a recent RAND study to use cell phone numbers, the process would require verification through call-back. Because matching could be substantially increased under this proposal, the value that this can bring to the rest of the process must be recognized: fewer duplicate records, better matching and more complete records.

The EHR Association strongly believes that a key component of accurate patient matching is the sharing of best practices on processes and education that demonstrate the value and need for every healthcare organization to improve their registration processes. In the absence of a national, unique identifier, best practices--in combination with evolving matching techniques, standardization of typical fields used in matching, and use of alternative unique identifiers--can produce substantial improvements. Expanding the set of fields for matching does not necessarily improve matching rates, as the fields remain subject to accuracy challenges in the registration process while unnecessarily complicating that process.

Patient identification and matching remains a paramount challenge to information exchange and optimized patient care. Because of the decades lost in this area (due to the Appropriations bill language that prohibits a national patient identification effort), the industry is in the process of developing of appropriate national standards in this area, as well as agreement on a larger overarching strategy. While this work is still active, particularly related to standards, we caution against overreaching policies that get ahead of standards development.

Instead, we strongly encourage greater involvement of the payer community in the conversations around patient matching, and we are pleased that the CMS proposed rule begins to address that approach. We believe the industry would be best served by their participation in the multi-stakeholder process underway. If payers were to respond to this challenge by taking varying approaches--either amongst themselves or simply inconsistent with larger healthcare industry efforts--it would do little to address the concerns and challenges because it would instead create yet another need for data

reconciliation. Varying approaches will actually create additional disparate information in the exchange environment, and it would certainly cause further burden on clinicians and other entities working with the data.

In asking about how to measure patient matching success, we believe that CMS is approaching it in such a way as to create real challenges with measurement. Rather than attempting to measure an algorithm's success before it is used, which would be difficult, we suggest the focus should instead be on the collection of uniform data elements, which most of the health IT industry does today. We do encourage adoption of standard data as well, such as that prescribed within the USCDI, given that good quality, consistently captured and described data increases the odds of successful matching.

We note, however, that there is no one action, technical or non-technical, that will fix this challenge, and we continue to look to CMS and ONC to help guide the development of a national strategy for patient matching in partnership with industry stakeholders. Addressing the challenge within different verticals of the healthcare industry at different times or in different ways (e.g. the payers here) will not solve the issue efficiently.

Additionally, the approach that is ultimately successful must retain elements that allow for flexibility even where a standard line of thinking and technical framework should be employed. The best approach for a given healthcare organization depends on several factors related to the population's characteristics, the way the information is used and managed, data quality, and algorithms employed by various systems involved in information exchange, among other factors. A successful matching strategy will consider the data quality, consistency, resilience, and recovery capabilities around the match. There must be a systematic way that is effective among providers, payers and vendors.