June 5, 2019

ONC

Administrator

Centers for Medicare and Medicaid Services

Attention: CMS–9115–P, Mail Stop C4–26–05,

7500 Security Boulevard, Baltimore, MD 21244–1850

Re: Trusted Exchange Framework and Common Agreement (TEFCA) Draft 2

Briljent appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-facilitated Exchanges and Health Care Providers.

Briljent is a highly acclaimed presence in the Medicaid Enterprise and health information technology (HIT) systems arena with a history of developing and delivering industry-leading solutions to a broad spectrum of government agencies and staff. Our team has provided HIT policy assistance to Medicaid agencies across all 50 U.S. states and 6 territories. We have expanded our services to health information exchange entities engaged with Medicaid in various states. Our team has deep experience with health information management and technology.

Our comments to this rule are specific to our areas of expertise and interest. Please find them as follows.

Comments

p. 17 re: "Participants and Participant Members are responsible for communicating this Meaningful Choice up to the QHIN who must then communicate the choice to all other QHINs. This choice must be respected on a prospective basis."

This requirement needs to be aligned with EHR certification standards to assure that there is a standard for documentation of consent, restriction, cancellation of consent or restriction, and signature (or electronic equivalent of validation).

Further, the process for obtaining patient choice is often performed by patient access or release of information teams and there needs to be a campaign to standardize at an operational level, perhaps with HIPAA privacy officers. Organizations such as AHIMA and HCCA may be valuable partners in this effort.

p. 27 re: "Principle 3 — Cooperation and Non-Discrimination: Collaborate with stakeholders across the continuum of care to exchange EHI, even when a stakeholder may be a business competitor"

ONC will need to continue ensure that TEFCA and the Information Blocking rule are in lockstep on the communication of sharing requirements and exceptions.

p. 46 re: "3.2 Data Quality Characteristics. To help confirm that QHINs exchange accurate patient demographic data that is used for matching, QHINs shall annually evaluate their patient demographic data management practices using the then applicable PDDQ Framework. The first such evaluation shall be conducted within eighteen (18) months after the QHIN has executed the Common Agreement."

We support the requirement to evaluate patient identity data management yearly.

We recommend that the first evaluation timeframe be shortened to six (6) months after contract execution.

p. 66 re: “The Participant Member may require such Individual User to assert his or her right to Individual Access Services to EHI in writing and may require such Individual User to use the Participant Member’s own supplied form, provided that the use of such a form does not create a barrier to or unreasonably delay the Individual User from obtaining access to the EHI. Each Participant Member shall provide Individual Users with the option of using electronic means (e.g., e-mail or secure web portal) to assert their rights for Individual Access Services to EHI.”

We support the reuirement to be able to submit forms electronically.

We strongly support not causing a barrier or unreasonable delay. However, barrier and reasonable delay should be more specifically defined.

p. 85 Request for Comment #8, “should the QTF specify a single standardized approach to Patient Identity Resolution across QHINs?”

We believe it is limiting to require one solution. However, we believe having a certification requirement for any solutions to validate the minimum success rates. Most organizations from providers to HIEs to state Medicaid systems, do not accurately know their duplicates rate, nor have documented process for resolution of duplicates or improper merges. Standards and tools for identifying the rate need to be promoted. An acceptable level of duplicates rate needs to be established and reported, possibly in conjunction with other quality measures. As an organization whose membership often are in the roles to diagnose and resolve patient identity integrity, the American Health Information Management Association would be an appropriate entity to support this standard development.

This question was also asked on the CMS interoperability rule. CMS and ONC should stay aligned as to who will own this mandate and oversight as the rules are finalized.

Conclusion

Briljent hopes that these comments are helpful in moving interoperability forward and greatly appreciates the opportunity to help guide the agency on this complex and increasingly important issue. Should you have any questions or seek additional information, please contact Susan Clark, Health Information Technology Subject Matter Expert, at sclark@briljent.com. We look forward to continuing the dialogue with your offices on this and other important matters.

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