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National Coordinator
Office of the National Coordinator for Health Information Technology
U.S. Department of Health & Human Services
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Submitted electronically: <https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-usehealth-it-and-ehrs>

Re: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Dr. Rucker:

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on the Office of the National Coordinator for Health Information Technology (ONC) Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Our member companies are engaged in a wide variety of activities, programs and research designed to improve health care quality and the health of enrolled populations. With their collaborating partners, health insurance providers develop programs and tools that emphasize evidence-based care, drive improved patient outcomes and advance care delivery, protect patient safety, and support quality reporting.

Section 4001 of the 21st Century Cures Act (Cures Act) requires the Department of Health and Human Services (HHS) to: (1) establish a goal for burden reduction relating to the use of EHRs; (2) develop a strategy for meeting that goal; and (3) develop recommendations to meet the goal. The statute directs the prioritization of several areas related to health IT, including: certification; standards; patient access to their electronic health information; and privacy and security of such information. Furthermore, it calls out reporting clinical data for administrative purposes, public health needs, and clinical research. Finally, the statute directs HHS to focus on federal initiatives such as the Promoting Interoperability Programs, the Merit-based Incentive Payment System (MIPS), and value-based payment models, as well as the alignment and simplification of quality measures across federal and non-federal payer quality initiatives. The recommendations are



expected to identify ways in which the Secretary and other entities can improve the clinical documentation experience and patient care.

AHIP and its member health insurance providers strongly support the vision outlined by Administrator Verma in her opening comments included in this report and are wholeheartedly committed to “programs, policies, and systems that put patients and their needs first.” Health insurance providers have long sought to ensure that consumers have the cost, quality and other information they need to make informed choices for themselves and their families. Member plans are working to harness big data and machine learning to empower clinicians with a more comprehensive view of their patients and envision the medical record as a tool to support the best possible care for the patient as noted by Dr. Rucker.

Furthermore, we agree with Secretary Azar’s assessment that the recommendations contained in this report could impact a significant number of health care providers that participate not only in the Medicare and Medicaid programs, but also will set a direction for the rest of the health care sector. While many of the recommendations are specific to federal programs, many others directly relate to private health insurance providers’ initiatives or have downstream effects on those plans, the clinicians with whom they work and the consumers they serve. It is within this context that we provide the comments below.

BURDEN REDUCTION GOALS

The report outlines three primary goals for reducing health care provider burden:

1. Reduce the effort and time required to record information in EHRs for health care providers during care delivery.
2. Reduce the effort and time required to meet regulatory reporting requirements for clinicians, hospitals, and health care organizations.
3. Improve the functionality and intuitiveness (ease of use) of EHRs.

The law defines interoperability as “the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user.” A Rand study, in conjunction with the American Medical Association, found that data limitations “continue to constrain practices’ ability to understand and improve their performance.” It also noted that practices are augmenting “their capabilities to collect and manage data from internal and external sources by investing in staff and information technology.” Ideally, the new information technology is meant to enable efforts such as behavioral health integration and care coordination. However, the clinicians with whom our member plans contract report that EHRs often create additional administrative work, crowding out patient care, and do not deliver true interoperability as envisioned in the statute. A key component not explicitly stated in the goals that is vital to the liquidity of data within the system to enable care coordination without special effort is overcoming the challenges associated with data blocking. According to



the Office of Management and Budget Unified Agenda, a separate proposed rule is under development on data blocking, among other issues, and we hope to see the two efforts synergistically improve interoperability.

Thus, we concur with the overarching goals as outlined by ONC of seeking to reduce documentation and regulatory burden as well as an improve the form and function of EHRs to better support patient care.

STRATEGIES AND RECOMMENDATIONS

After laying out the issues and challenges, the report breaks up proposed strategies and recommendations to mitigate provider burden associated with EHRs into four aspects:

1. Clinical Documentation,
2. Health IT Usability and the User Experience,
3. EHR Reporting, and
4. Public Health Reporting.

The groupings laid out by ONC are helpful in categorizing and cataloguing the issues to minimize overlapping recommendations. *AHIP generally supports the strategies and recommendations proposed by ONC.* However, we provide additional details below on ways in which the Draft Strategy could be improved from the perspective of health insurance providers.

Clinical Documentation

ONC Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.

We agree that clinical documentation, with or without an EHR, can be an onerous process. We further agree that with the widespread usage of EHRs to capture clinical documentation, the medical record has grown without a commensurate increase in utility of the information captured. *Thus, AHIP supports streamlining documentation requirements, leveraging existing data captured as part of the clinical workflow, and collecting ongoing stakeholder feedback.*

The ONC and CMS should, however, proceed with caution to avoid unintended consequences as clinical documentation is used for a variety of care coordination, quality improvement, billing, legal and other administrative purposes. If CMS extensively waives documentation under Alternative Payment Models (APMs), for example, that streamlined documentation method is likely to carry over to patients covered by private plans. This could hamper risk analyses to identify consumers who would benefit from additional care management. Or, to the extent some of those



fee-for-service beneficiaries move to Medicare Advantage (MA), the streamlined documentation may have unintended consequences on MA plan payments.

*Moreover, we remain concerned with CMS' recent changes in the calendar year 2019 Medicare physician fee schedule final rule, which alters the payment structure for Evaluation and Management (E/M) services in an effort to reduce documentation burden. Again, we support reduction of the documentation requirements, but in this case CMS designed changes to payment instead of actually making fundamental changes in the E/M documentation and coding guidelines. Moreover, CMS bypassed the AMA CPT Editorial Panel committee charged with reviewing the underlying codes and descriptions. As the Medicare fee schedule underpins many private plan payments, this will have a cascading effect that will, in some cases, require burdensome workarounds for both clinicians and health insurance providers. **The ONC and CMS should take care to ensure that changes to reduce provider burden do not result in a reduction of clinically useful data from the medical record.***

ONC Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.

AHIP and its members support efforts to engage clinical stakeholders and spread best practices. We support clinicians leveraging “data already present in the EHR to reduce re-documentation in the clinical note” per Strategy 1 recommendation 2. However, here too we urge caution in proceeding. The use of “copy and paste” in the EHR should be used sparingly and only as appropriate per the HHS Office for Civil Rights (OCR). The information carried forward should be justifiable and not simply transfer information from prior visits that may no longer be relevant. We support the ONC and CMS working with clinical stakeholders to clarify appropriate techniques and spread best practices but discourage CMS from regulating the issue.

ONC Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

Medical management tools, including prior authorization, are important to promote patient safety and ensure treatments are supported by scientific evidence, especially given wide variations in practice. AHIP, the AMA, and other stakeholders released a consensus statement in 2018 acknowledging that prior authorization can be burdensome for all involved—health care providers, health plans, and patients. The groups identified opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The following five areas were offered as opportunities for improvement in prior authorization programs and processes that, once implemented, could achieve meaningful reform.

1. Selective Application of Prior Authorization.
2. Prior Authorization Program Review and Volume Adjustment.



3. Transparency and Communication Regarding Prior Authorization.
4. Continuity of Patient Care.
5. Automation to Improve Transparency and Efficiency.

AHIP believes that moving toward industry-wide adoption of electronic prior authorization transactions based on existing national standards could streamline and improve the process for all stakeholders. Additionally, making prior authorization requirements and other formulary information electronically accessible to health care providers at the point-of-care in EHRs and pharmacy systems will improve process efficiencies, reduce time to treatment, and potentially result in fewer prior authorization requests because health care providers will have the coverage information they need when making treatment decisions. Technology adoption by all involved stakeholders, including health care providers, health insurance providers, and their trading partners/vendors, is key to achieving widespread industry utilization of standard electronic prior authorization processes. End to end solutions for automated prior authorization are not yet available and once they become available it will take time for stakeholders to migrate to the new technologies. ***Thus, incentives by CMS to adopt technologies that can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes would hasten progress and be supportive of the efforts already underway by private payers.***

AHIP is in the process of coordinating a demonstration project in 2019 with vendors offering prior authorization automation solutions, health insurance providers and physician practices to evaluate the impact of scalable solutions. ***Thus, AHIP and its members appreciate the recommendation to work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.*** We will keep ONC and CMS apprised of our progress on this pilot. We are also engaged with CMS in its development of the Document Requirement Look-up Service (DRLS) demo that would enable providers to electronically query the steps needed to get coverage of items or services and provide supporting documentation starting with e-prescribing of durable medical equipment. We commend CMS for working with HL7's Da Vinci Project, which includes a number of private payers, as part of this demonstration to further develop data and electronic transaction standards as existing standards are not sufficient to fully automate the process. We note, however, that HHS has yet to release its rule on claims attachments. Adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) would further reduce the administrative burdens associated with prior authorization. ***We urge CMS to continue its support of the Da Vinci project as it begins its expanded work on quality measurement and other use cases.***

One issue we want to raise about Strategy 3 Recommendation 2 is the notion of standardized templates. Plans have encountered challenges with standardized templates used by solutions providers that are not sufficiently flexible to customize questions based on the relevant clinical condition, item or service. In fact, their use can increase the likelihood of administrative denials



and the need for subsequent follow-up communications needed to make a comprehensive prior authorization determination. The Massachusetts Department of Insurance (DOI) mandated a prior authorization form, which was originally intended to reduce provider administrative burden, but is now incompatible with the automation technology currently on the market. ***Inflexible or static templates will impede rather than facilitate the automation of prior authorization requests.***

Health IT Usability and the User Experience

ONC Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.

Health insurance providers are far more than risk bearing entities; they strive to keep consumers well, and provide access to high-quality, affordable care when they are not. Health insurance providers are evolving with the provider community under value-based care transformation. As part of this, plans have invested in advanced analytics to better identify the needs of consumers and surface opportunities for care improvement to providers. Plans have a much broader view of the patient's care than any individual provider, but the lack of true interoperability hinders dissemination of important information to providers. Actionable clinical decision support (CDS) is constrained by the inability to push and pull information to and from EHRs without special effort and as part of the clinical workflow.

Many plans provide portals for providers within value-based arrangements with robust data to assist with adherence to the evidence base, care coordination, and quality improvement efforts. However, providers must log-in and out of the various portals based on each patient's insurance. Although Directed Exchange provides a method of sending Health Insurance Portability and Accountability Act's (HIPAA) secure messages to providers, it does so in a provider's centralized mailbox, burdening the provider with the additional task of applying the information contained in the message to the member's chart. Although secure and mature, this is not optimal as it requires more steps for the clinician and a lower likelihood that the information will be incorporated into the care plan. Fast Healthcare Interoperability Resources (FHIR) and CDS hooks can be leveraged to empower value-based payers to insert CDS directly into a patient record so providers can be alerted to potentially helpful information at the point of care. ***AHIP supports the recommendations to improve not only the design of EHRs to fit into the clinical workflow, but also to integrate clinical decision support in a way that is truly interoperable with other stakeholders.***

We note that CMS is also planning to award an Artificial Intelligence challenge grant to support value-based care. Many of the potential participant vendors suggested implementing activities such as predictive analytics, which insurers are already pursuing. Similarly, to DRLS, this will likely necessitate health insurance providers voluntarily developing application programming interfaces (APIs) to provide access to the claims data that will enable these new functions. ***CMS***



should consider a more comprehensive, voluntary, multi-payer demonstration to harness big data through APIs rather than going use-case by use-case, payer by payer.

We also support the recommendations to improve clinical functionality and presentation of clinical data. We agree that the advancement and integration of emerging technologies such as speech recognition and machine learning into EHRs could contribute to simplifying clinical documentation. We further support efforts by ONC and vendors to better enable providers to retrieve the necessary information with ease as it will improve the likelihood that the care will be evidence-based and of high quality.

ONC Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.

Improving the data within EHRs, the way in which it is displayed to providers and the usefulness of the information is key to improved outcomes. *We support ONC's recommendations to optimize the user interface of health IT that will improve the efficiency, experience, and end user satisfaction.*

EHR Reporting

ONC Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.

AHIP supports the strategy to address program reporting and participation burdens. AHIP supported CMS's efforts to replace the Hospital Meaningful Use program and Physician Advancing Care Information performance category with Promoting Interoperability to support greater electronic health record interoperability and patient access. We also agree that these programs can and should be used to incentivize innovative uses of health IT, as well as evolve through improving current health IT measures and developing new health IT measures that focus on interoperability, relevance of measure to clinical practice and patient improvement, and electronic data collection that aligns with clinical workflow. To the extent that incentives can be made to safety net providers serving Medicaid and uninsured patients, we believe the federal government will guard against a two-tiered system of care for the most vulnerable patients.

ONC Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.

We agree that physicians and hospitals encounter difficulty accessing data both within their data systems and across health IT and other electronic platforms for the purposes of quality reporting. *While we support the short-term work of spreading best practices around data*



mapping, we urge ONC to focus on the longer-term solution of adopting additional data standards.

CMS's Blue Button 2.0 Initiative currently provides Medicare fee-for-serve beneficiaries information like an Explanation of Benefits (EOB) provided by private payers but is expanding into availability of claims data to third party vendors. We support CMS in adopting an open API approach to HHS electronic administrative systems, but caution that providing claims data to patients does not achieve interoperability. It continues to create a band aid solution that replaces the paper carried by patients with an electronic version but does not give providers access to all the information they need at the point of care or health insurance providers the clinical information they need to assist in evidence-based, coordinated care.

Our member health insurance providers are also taking a consumer-centric approach to making readily available the benefits, quality and price information consumers need to make informed decisions about their care. Health insurance providers continue to invest in consumer portals, apps and other technologies to communicate information to consumers where and when they need it. *However, we caution against requiring private payers to develop open APIs for third party vendors to access claims data as numerous legal, ethical, technological, and other questions remain unresolved.* Moreover, CMS is vetting more than one thousand app developers to determine appropriateness for accessing Medicare data for consumer security and privacy. It should serve as a beta site for such consumer-directed access and share findings with private payers to inform their efforts. This would spur innovation rather than each payer duplicating efforts and drawing funds away from further innovation. Furthermore, we urge that any standard(s) developed as part of this work for transactions or extracts be flexible enough to account for changes in underlying technology and or capabilities.

ONC Strategy 3: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.

AHIP appreciates ONC's and CMS's continuing efforts to advance quality measurement and reporting programs that contribute to the availability of consistent and reliable performance information while at the same timing seeking to minimize the burden on providers. Harmonization, simplification and refinement of quality measure sets used in CMS' quality reporting and value-based programs is necessary to ensuring these programs continue to incentivize evidence-based care. AHIP remains committed to efforts to reduce provider measure reporting burden and align measures across public and private payers. We have been deeply involved in the American Hospital Association's Measures That Matter Collaboration, which brings together the major national associations representing hospitals and health plans to provide strategic recommendations for improving hospital performance measurement in public and private reporting and pay-for-performance initiatives. AHIP is also a founding member of the Core Quality Measures Collaborative (CQMC) – the result of a partnership between AHIP, its member plans, CMS and



other health system stakeholders to promote alignment of quality measures across public programs and the private sector in an effort to reduce provider burden and provide consistent information to consumers on which to base their health care decisions. *We applaud CMS for its efforts to streamline quality reporting programs and align with private payers through its work on the CQMC and urge it to continue involvement as more measures move to electronic specifications derived from EHRs.*

We encourage a first-year test reporting approach for all measures. We also believe it would benefit the field at large if CMS and ONC would continue to evaluate the current landscape and future directions of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project. The CQMC does not yet incorporate many e-measures as there are few and they are operationally more difficult to implement for providers and payers alike. Thus, AHIP encourages ONC and CMS to explore less burdensome approaches to electronic quality measurement through pilot programs that incorporate private payers and offer reporting program incentives. Enabling providers and EHR systems to connect more seamlessly with payers is one example of where appropriate incentives can benefit patient's health care experience as well as outcomes. By leveraging more information about a patient's whole health, payers can proactively impact a patient's health for the better by closing gaps in care and resolving care coordination. Incentives may assist in piloting programs to determine additional ways to ease any existing burdens and increase uptake of a more connected system.

Public Health Reporting

ONC Strategy 1: Increase adoption of electronic prescribing of controlled substances (EPCS) and retrieval of medication history from state prescription drug monitoring programs (PDMP) through improved integration of health IT into provider workflow.

We encourage the Federal agencies to work with OCR to ensure that the HIPAA Privacy and Security Rules and corresponding guidance support these activities. *We also urge HHS to push for health insurance providers and pharmacy benefit managers (PBMs) to have access to state PDMPs in order to have a more complete picture of their members' controlled substances prescriptions.* Virtually no states allow such access to this information at present, hampering efforts by plans and PBMs to assist. Moreover, such information should be accessible in a machine-readable format so that plans do not have to query the system one member at a time. This information will allow health insurance providers to target assistance to particular providers with opportunity to improve prescribing patterns and specific patients for whom care management and other services are needed. Health insurance providers are committed to protecting the security and privacy of this information, and to using it solely to improve care for members.

ONC Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians.



Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.

AHIP supports ONC's strategy to harmonize reporting requirements across federally funded programs that rely on EHR data. We also agree that HHS should continue to monitor, test, and support the development of technical standards for applying security labels and meta-data (commonly referred to as "data segmentation") to health information in a consistent manner to reflect privacy requirements, and enable health care providers to comply with existing requirements. Furthermore, we also support ONC's recommendation that healthcare providers and their HIT vendors better understand the HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder (SUD) health information under Title 42 of the Code of Federal Regulation (CFR) Part 2 in order to better facilitate electronic exchange of health information for patient care.

However, as we have advocated consistently in the past, we urge HHS to take a stronger position by recommending that Congress modernize the regulations in 42 CFR Part 2 to align with the existing HIPAA privacy requirements for uses and disclosures of individuals' health information for treatment, payment, and health care operations. This is critically important to improving patient safety and care coordination. AHIP and its members support modernizing existing federal regulations by requiring that the medical records of patients with SUDs be treated the same as the medical records of patients with other chronic illnesses, a step that would promote consistency of access to vital medical information for public and private payers. By ensuring that health care professionals and health insurance providers have appropriate access to a patient's complete medical record (including addiction-related information), alignment would protect patients' access to safe, effective, high quality, coordinated care, and treatment that addresses the full scope of their health care needs all while maintaining the patient right to privacy and boosting consumer protections.

Thank you for the opportunity to provide these comments. We appreciate ONC's efforts to advance interoperability while at the same time reducing the burden associated for all stakeholders involved. We look forward to continuing our work with ONC in this area. Please do not hesitate to connect me at 202-778-3246 or dllloyd@ahip.org if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Danielle A. Lloyd".

Danielle A. Lloyd, MPH
Senior Vice President, Private Market Innovations and Quality Initiatives