



## National Association for the Support of Long Term Care

January 28, 2019

Donald Rucker, MD  
National Coordinator  
Office of the National Coordinator for Health Information Technology (ONC)  
330 C Street, SW  
Room 7033A  
Washington, DC 20201

*Sent Via Electronic Submission*

*RE: Draft Strategy on Reducing Burden Relating to the Use of Health IT & EHRs*

Dear Dr. Rucker:

The National Association for the Support of Long Term Care (NASL) appreciates the opportunity to share our comments with the Department of Health & Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) regarding the *Strategy on Reducing Regulatory & Administrative Burden Relating to the Use of Health IT & EHRs*, which was released on November 28, 2018.

NASL is a trade association representing suppliers of ancillary services and providers to the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies whose physical therapists, occupational therapists and speech-language pathologists furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities as well as to beneficiaries in other long term and post-acute care settings. NASL members also include both vendors of health information technology (health IT) that develop and distribute full clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living as well as skilled nursing and ancillary care and services. In addition, NASL members include providers of clinical laboratory services, portable x-ray/EKG and ultrasound, complex medical equipment and other specialized supplies for the LTPAC sector. NASL is a founding member of the Long Term and Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.

NASL is pleased to submit these comments to the ONC for consideration.

NASL understands that HHS' draft [\*Strategy on Reducing Regulatory & Administrative Burden Relating to the Use of Health IT & EHRs\*](#), is required by the *21st Century Cures Act (Cures Act)* and intended to ameliorate provider burden.

NASL appreciates that HHS solicited input from workgroups comprised of a variety of federal agencies. NASL and its membership work with a variety of federal agencies such as the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control & Prevention (CDC), which have an impact on operations in the LTPAC sector. We think it is important to consider each of the agencies that impact healthcare operations when trying to assess and reduce regulatory and administrative burden.

We wish to underscore that much of the focus on reducing burden is an outcropping of CMS' EHR Incentive Program (now Promoting Interoperability Program) and seeks to address the concerns raised by eligible professionals. CMS has recognized the discrepancy between incentivized and non-incentivized providers. For example, CMS notes in the Medicare *Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR) Final Rule* that, "...adoption of health IT among providers in the post-acute care market, such as skilled nursing facilities, continues to lag behind hospitals and providers of ambulatory care services. In addition to facing significant resource constraints, post-acute care providers were not included as an eligible provider type under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs." Even so, long term and post-acute care, behavioral health or other providers that were excluded from the *Health Information Technology for Economic & Clinical Health (HITECH) Act*, are striving to increase the electronic exchange of information and promote interoperability in our settings and NASL represents their health IT partners that share that same goal.

NASL is buoyed by HHS' emphasis on the growing importance of health information technology and interoperability to improve care coordination. We welcome your outreach to NASL and other key stakeholders who have much to contribute to an overall, cohesive, HHS-wide effort to reduce burden, limit duplication and speed interoperability.

NASL has focused our comments on a few key recommendations with regard to the HHS draft strategy to reduce burden.

## **Patient Matching**

**One of the greatest barriers to interoperability is poor patient record matching.** It is not mentioned in HHS' strategy, which we presume relates to the current legal prohibition on developing a national patient identifier.

On January 15, 2019, the U.S. Government Accountability Office (GAO) released a new report on

patient matching, as required under Section 4008 of the *21st Century Cures Act*. The report was entitled, *Health Information Technology: Approaches & Challenges to Electronically Matching Patients' Records Across Providers* ([GAO-19-197](#)). The report confirms that incomplete or inconsistently formatted data can make patient matching difficult at best.

Currently, patient record matching relies on various algorithms that draw on captured patient demographic information such as name, date of birth and address. These fields are unreliable and subject to variation. For example, the use of nicknames and simple misspellings can make matching demographics difficult. Ironically, to reduce error rates, clinicians typically must manually check for the match, perhaps interrupting workflow and certainly adding burden.

Another challenge to patient matching is the federal prohibition against HHS using funds to promulgate or adopt any final standard providing for a national patient identifier. On May 9, 2018, as we have done previously, NASL and our colleagues sent a letter to appropriators in the U.S. House of Representatives and U.S. Senate requesting that language be added to the Labor-Health & Human Services (Labor-HHS) appropriations bill, which would allow ONC and CMS to provide technical assistance to private-sector led initiatives that support a coordinated national strategy and promote patient safety by accurately identifying patients with regard to their health information. NASL believes that unless we address the challenges with patient record matching now, the difficulties are likely to increase along with greater exchange of health information.

### **Focusing More on “The What” – Not “The How”**

Much work has been done regarding federally recognized technical standards, policies, best practices and procedures. Rather than focusing on the technical mechanism of exchange (*aka* the “how” of sending data from point A to point B) and building yet another network for exchange, NASL believes that there should be a greater emphasis on using – and even consolidating – those standards and systems for exchange. By leveraging existing, working networks – some of which were highlighted by ONC during its Trusted Exchange Framework and Common Agreement (TEFCA) kickoff meeting in July 2017– there could be greater attention paid to improving guidance on how best to use data received from another provider and make data exchange more useful to clinicians and patients.

Interoperability extends beyond EHR-to-EHR; interoperability depends upon registries, device integration, application programming interfaces (APIs) and other web services for accessing a patient’s medical record. It also must extend to the providers that did not benefit from the federal incentive programs that have driven the larger, acute and ambulatory care systems to develop interoperability solutions and create frameworks. Groups like long term and post-acute care and behavioral health providers should be incentivized to catch up.

NASL believes that ONC – and the healthcare system as a whole – would benefit from driving consensus and agreement on what is most needed and what is already being done in the industry

today. **Focusing on the “what” – the information to be shared – will help make the data that is shared more useful to the providers who need that information.** By considering how to incorporate technology and shared information into the clinical workflow, the focus will shift from simply moving data from one point to the next to how to use shared data to improve clinical outcomes.

We still await ONC’s next proposal regarding TEFCA, which we understand is intended to establish a structure for health information exchange across all settings. It remains unclear how federal government initiatives such as TEFCA will meld together to improve care coordination and achieve much needed efficiencies without adding burden that CMS is trying to eliminate under its Meaningful Measures initiative.

## **Clinical Documentation**

- **Leverage data already present in the EHR to reduce redocumentation in the clinical note.**

### *NASL Position*

Reuse of data already present in the electronic health record (EHR) is one way to achieve greater efficiency. By allowing health IT systems to pre-populate certain patient information, the clinician can focus on confirming critical clinical information rather than spending time re-entering existing data. It also may help to prevent human errors in re-entering information incorrectly – errors that can be consequential in the case of illegible medication orders that may be faxed or keyed into an electronic system incorrectly, for example.

- **Incentivize adoption of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes.**

### *NASL Position*

Many of NASL member companies already produce software products that can generate and exchange standardized data. Clearly, we support investing in health IT to manage data and clinical documentation needs. We believe that Congressional policy will drive any prior authorization process, and do not agree that HHS should dictate the IT structure that providers need. Instead, usability should be aligned to workflow, which in turn will reduce burden.

ONC’s *2018 Report to the Congress* highlights progress in health IT adoption – 96% of nonfederal acute care hospitals and 78% of office-based physicians as of October 2018. We think that is evidence that providers respond to incentives. So, if the use of health IT was incentivized in LTPAC settings, which did not receive incentive funding under Meaningful Use, then we believe that LTPAC providers would more readily adopt health IT, which in turn would reduce their burden.

## Health IT Usability & the User Experience

- **Standardize medication information within health IT.**

### *NASL Position*

NASL agrees that standardizing medication information used by various health IT systems is useful. Moreover, receiving a patient's medication list from the previous provider is essential. In the case of skilled nursing facilities (SNFs) and other post-acute care (PAC) providers, we have requested that hospitals be required to send medication information as part of participation in CMS' Promoting Interoperability Program.

We also encourage HHS to consider the development timelines that each of its agencies impact. As HHS reviews the divergent federal requirements that impact LTPAC providers, we ask that HHS consider the time that is needed to integrate changes to existing systems or added functionality. For example, health IT developers will need to reprogram software and interfaces that currently use the NCPDP Script 10.6 standard to be compliant with the new NCPDP Script 2017071 standard – and its different and added functionality – by January 1, 2020. That is not a small endeavor. Even more challenging is planning that change simultaneously to changes required by CMS' shift from the Resource Utilization Group, Version IV patient classification system (RUG-IV) to Patient-Driven Payment Model (PDPM), along with any other adjustments that may be needed as CMS revamps its Quality Improvement Evaluation System (QIES) and Automated Survey Processing Environment (ASPEN) platform, which supports quality and other reporting to CMS. We support HHS and its agencies' efforts to drive change and adoption of health IT. These are not minor endeavors; each effort demands time and consideration to ensure continuity of care and operations during the transition to these new systems and processes. Massive changes such as replacing a payment or reporting system also are likely to curtail LTPAC health IT vendors' capacity to focus on innovations and expanding interoperability. NASL stands ready to work with CMS, ONC and HHS in facilitating such changes.

- **Promote understanding of budget requirements for success.**

### *NASL Position*

NASL wholeheartedly agrees that providers must understand how to budget for the health IT that is needed to meet the challenges ahead. The efficiencies and clinical insights that today's health IT can provide cannot be achieved with a one-time, single purchase. Providers should expect software products to be updated periodically to adjust to minor changes and new releases. Major upgrades may be needed periodically, too. For example, NASL member companies that developed software for skilled nursing facilities (SNFs) had to be updated in order to accommodate new and recently revised Medicare Requirements for Participation issued by CMS.

In 2019, the SNF Prospective Payment System (SNF PPS) is being overhauled as CMS shifts

from the RUG patient classification system to the new PDPM. That massive change demands a re-write of existing software products. Additional updates and upgrades surely will be on the horizon as CMS implements a new official Part D e-prescribing standard next year as well.

Providers must plan for more than just the initial investment in health IT. There are costs for ongoing technical support for end users and training of clinical staff along with required technical resources to support upgrades, system maintenance, system upgrades, troubleshooting, system backup and disaster recovery functionality. Cybersecurity concerns, monthly cost of internet, network and software services, and new IT personnel also should be factored into a healthy IT budget. Unless the same budgetary approach used for other essential costs is applied to planning for evolving health IT needs, providers will be unprepared to meet the unique challenges and opportunities ahead.

## EHR Reporting

- **To the extent permitted by law, continue to provide states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers.**

### *NASL Position*

To reduce burden, the government must understand the budget limitations present in the LTPAC sector. **Paying for each transaction or exchange of information is not a viable interoperability strategy for health IT vendors and providers in this sector, which received no incentive funding for health IT adoption.**

The government also must recognize there are additional challenges associated with a siloed approach. For example, CMS is requiring that Medicare fee-for-service providers implement PDPM, while allowing Medicare Part C to continue using the RUG patient classification system. Rather than having one cohesive system, providers must contend with differing systems and requirements for both Medicare Parts A and C – to say nothing of state Medicaid requirements that often figure into care of patients who are dually eligible for Medicare and Medicaid.

NASL agrees that HHS should continue to provide states with federal Medicaid funding, to the extent permitted by law, so as to encourage adoption of health IT systems and interoperability among Medicaid health care providers. We recommend that CMS and ONC redouble efforts to promote Medicaid interoperability in the post-acute sector because Medicare incentive funding (Promoting Interoperability) is not available to the sector because LTPAC was excluded from those incentives. Connecting the post-acute care providers to hospitals, for example, is of utmost importance.

LTPAC providers are major electronic exchange partners of those who were eligible to

participate in both the Medicare and Medicaid Incentive Programs and to receive incentive funding under the *Health Information Technology for Economic & Clinical Health (HITECH) Act*. Yet, without extending health IT funding to LTPAC and other sectors left out of *HITECH*, we will not realize the full promise of health IT in achieving a truly, patient-centered care continuum. ONC recognized in ONC [Data Brief #39](#) that “EHR adoption and interoperability of SNFs’ health information systems is critical to facilitating transitions of care.” We agree and seek to eliminate the digital divide that still exists for those caring for America’s seniors. **To reduce burden, NASL recommends improving the adoption and use of health IT in LTPAC should be a top priority as we work toward greater interoperability.**

## Public Health Reporting

- **HHS should convene key stakeholders to inventory reporting requirements, and work together to identify commonly reported data for state and federal programs.**

### *NASL Position*

NASL health IT vendor members are keenly aware that federal and state reporting requirements are often duplicative. Since HHS has an interest in promoting efficient, effective quality care, we agree that HHS should convene key stakeholders to inventory existing reporting requirements, identify commonly reported data and to recommend how to streamline these requirements. **We recommend that HHS begin by looking at requiring one set of data for a patient that transfers from the hospital to SNFs/NFs notwithstanding whether the patient is covered under Medicare Parts A, B or C.** It would reduce burden to standardize what information should flow between the hospital, SNF/PAC setting and Medicare Advantage plan in these three federal programs.

- **HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.**

### *NASL Position*

NASL believes that harmonizing the reporting requirements across federally funded programs could be the most effective way to reduce provider burden.

For example, CMS’ draft *IMPACT Act* measure on the Transfer of Health Information/ Medication Profile includes some of the same data elements as currently are required to transfer with the patient in accordance with the Long Term Care Facilities’ Requirements for Participation in the Medicare Program. There are additional parallels to data elements in the Common Clinical Data Set (CCDS). There are three different sets of data to transfer with the

patient. We believe that this is a good example of how standardizing these data elements would help to reduce burden and make health information exchange across providers more useful.

### ***Conclusion***

NASL welcomes the opportunity to discuss any of these recommendations.

Sincerely,

A handwritten signature in black ink that reads "Cynthia Morton". The signature is written in a cursive style with a large initial 'C'.

Cynthia Morton  
Executive Vice President