January 28, 2019

Dr. Don Rucker
National Coordinator
Office of the National Coordinator for Health Information Technology (ONC)
Department of Health and Human Services

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services

Submitted electronically to: https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs

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

Dear Administrator Verma and Dr. Rucker:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 165,000 other provider organizations, we appreciate the opportunity to submit comments regarding the Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Additionally, Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments reflect the concerns of our owner hospitals and health systems which, as service providers, have a vested interest in ensuring that HHS reduces provider and clinician administrative and reporting burdens.

Premier supports efforts to transform healthcare through the power of data and health information technology (IT). It is essential to address ongoing health IT interoperability challenges so that providers can improve care delivery, patient safety and performance, and to drive operational efficiencies. Premier continues to advocate for, develop and implement innovative solutions to achieve open data access across health IT systems and technologies to support the industry's value-based care transition across the care continuum. We appreciate the opportunity to submit comments on HHS' recommendations to deliver relief from the regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries. Below, we provide general comments about the report and then address specific categories of HHS' recommendations.

GENERAL COMMENTS

Premier appreciates HHS' efforts to implement provisions of the 21st Century Cures Act (Cures) related to reducing unnecessary regulatory burden and costs for providers and clinicians. We also look forward to timely implementation of all of Cures' health IT provisions (Sections 4000-4006) as many are interdependent. Premier urges HHS to recognize the true financial impacts and administrative burdens incurred by hospitals, health systems and clinicians in implementing administrative and reporting

requirements. Health systems and their associated clinicians face daily challenges from the voluminous regulatory requirements imposed by Medicare which can stand in the way of high-quality, safe and efficient care for beneficiaries.

We support HHS' prior efforts to harmonize compliance, administrative and reporting requirements across all federally-funded programs and urge HHS to accelerate activities to focus on programs that require the same or similar EHR data from healthcare providers. While we believe that the report is a good first step, we are disappointed that **the report does not adequately address ongoing provider administrative and reporting challenges that impede providers' efforts to improve care delivery, patient safety and performance, and drive operational efficiencies**.

CMS and ONC should explicitly address each of the concerns and problems identified in the report and link the recommendations to the associated challenges. We urge **ONC and CMS to identify specific HHS actions rather than offer suggestions of potential HHS considerations**. For example:

- On page 15, "Consistent with HIPAA, HHS *could* expand on current work to identify common data elements and standardized templates ……. HHS *could* also explore ways to incentivize clinicians to adopt technology certified to conduct these transactions according to recognized standards……HHS *could* engage a wide variety of payers, health care providers, and other third-party intermediaries in working toward robust standards-based automation of these transactions."
- On page 18, the report notes that, "HHS *could* expand its strategic focus on the future of eCQMs and how to ensure health care providers increasingly transition to electronic measurement and reporting" ….. and "HHS *could* further explore innovative approaches to electronic quality measurement that leverage emerging technologies, while incentivizing clinicians to help develop these approaches.

Premier recommends that CMS and ONC develop a more granular plan, including time periods for specific activities and tasks in order to implement the proposed recommendations. The plan should describe the inter-relationships between and inter-dependencies of recommendations. **We urge HHS to more clearly depict those recommendations within the purview of the federal government and to identify the specific agency (ies) to enact each recommendation.** For those recommendations requiring the participation of private sector entities, we urge HHS to enumerate those stakeholders and specific organizations. Once the draft report is revised/enhanced, HHS should disseminate the report for further public engagement. **We recommend that HHS convene stakeholders to help prioritize the recommendations and to facilitate the public-private sector collaboration required for success.**

Premier and its member hospitals have long been at the leading edge of developing, measuring and delivering high-quality, effective, efficient healthcare. Based on our members' experiences, **we offer several areas for continued and ongoing regulatory and administrative burden reduction.** These include: **more reasonable timelines, increased provider flexibility, more appropriate and valuable quality and promoting interoperability measures, reduced program overlap, elimination of redundant and duplicative administrative and reporting requirements and more timely access to appropriate data needed to improve beneficiary care**.

Below, we offer comments regarding the report's four (4) major categories:

CLINICAL DOCUMENTATION

HHS identifies several strategies and recommendations to reduce burdens relating to clinical documentation:

Clinical Documentation

- Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.
    - o Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.
    - o Recommendation 2: Leverage data already present in the EHR to reduce re-documentation in the clinical note.
    - o Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.
    - o Recommendation 4: Waive documentation requirements as may be necessary for purposes of testing or administering APMs.
- Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.
    - o Recommendation 1: Partner with clinical stakeholders to promote clinical documentation best practices.
    - o Recommendation 2: Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.
- Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.
    - o Recommendation 1: Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization.
    - o Recommendation 2: Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, and payers.
    - o Recommendation 3: Incentivize adoption of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes.
    - o Recommendation 4: Work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.
    - o Recommendation 5: Coordinate efforts to advance new standard approaches supporting prior authorization.

Accountable care organizations (ACOs) and other alternative payment models (APMs) need more and timelier data on their patients. **We support the recommendation to offer flexibility to APM participants**. We urge CMS to provide more timely data, including data about substance use, on an ongoing basis to further help providers be successful**.** While we appreciate CMS' efforts to expand the data it makes available to ACOs, the agency could and should go further. An ACO's success is dependent on the timely transfer of patient information and coordination of patient care. Since Medicare beneficiaries have the right to seek care from any provider that accepts Medicare, it can be a challenge for ACOs to monitor the services received by their aligned patients. **We recommend that CMS and ONC accelerate approaches to ensure ACOs have access to more timely and complete information on beneficiaries' care, such as through alerts or portals that provide ACOs access to claims information upon CMS receipt and prior to CMS processing.**

Beyond provider and clinician burdens, Premier believes that there are significant administrative inefficiencies, coordination and quality of care, and patient-safety issues with current manual prior authorization processes. **Premier supports HHS recommendations regarding prior authorization**. We have work underway to automate the clinical prior authorization process by integrating existing

information from EHRs and believe that integrating electronic prior authorization (ePA) capabilities within EHR systems will be transformative. **We recommend that HHS require certified EHRs to support ePA applications, and we urge CMS to incentivize providers to use health IT for prior authorizations by giving them credit within the Promoting Interoperability program for using health IT-enabled prior authorization.** We support HHS efforts to work with providers, standards development organizations, commercial payers, and other stakeholders to better coordinate efforts to develop, adopt and implement more harmonized approaches for prior authorization to address the inconsistent and opaque preauthorization requirements imposed by health plans, prescription drug plans and durable medical equipment suppliers.

HEALTH IT USABILITY AND THE USER EXPERIENCE

The report offers 4 strategies and multiple recommendations about Health IT Usability and the User Experience:

HEALTH IT USABILITY AND THE USER EXPERIENCE
- Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.
    - Recommendation 1: Better align EHR system design with real-world clinical workflow.
    - Recommendation 2: Improve clinical decision support usability.
    - Recommendation 3: Improve clinical documentation functionality.
    - Recommendation 4: Improve presentation of clinical data within EHRs.
- Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.
    - Recommendation 1: Harmonize user actions for basic clinical operations across EHRs.
    - Recommendation 2: Promote and improve user interface design standards specific to health care delivery.
    - Recommendation 3: Improve internal consistency within health IT products.
    - Recommendation 4: Promote proper integration of the physical environment with EHR use.
- Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.
    - Recommendation 1: Standardize medication information within health IT.
    - Recommendation 2: Standardize order entry content within health IT.
    - Recommendation 3: Standardize results display conventions within health IT.
- Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.
    - Recommendation 1: Increase end user engagement and training.
    - Recommendation 2: Promote understanding of budget requirements for success.
    - Recommendation 3: Optimize system log-on for end users to reduce burden.
    - Recommendation 4: Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.

Premier believes that achieving interoperability across the care continuum and **assuring data availability at the point of care and within the clinical workflow must be a top ONC and CMS priority**. Stimulus funding (government supported $30 billion) flowed to EHR vendors, while the penalties and burdens for not implementing certified technology and achieving interoperability remains with providers, creating provider dependence on their EHR vendors. Premier believes that existing policy levers and incentives continue to unfairly target and penalize providers (i.e., hospitals, health systems and clinicians). **We urge HHS to use specific policy levers (such as the CEHRT testing and certification program and EHR Reporting Program) to hold EHR vendors accountable for demonstrating and ensuring interoperability (particularly providing app developers access to and interaction with data in the workflow) and usability of their products.** Legacy EHR platforms still

impede and/or do not allow real time data flow to/from EHRs and clinical workflow. Furthermore, EHR vendors retain practical control over clinical data, limiting third party application development and innovation and provider data access.

We urge ONC to accelerate its efforts to propose the Trusted Exchange Framework and Common Agreement (TEFCA) and to require specific interoperability standards (transport, syntax, and sematic) along with technical implementation specifications for health IT systems, EHRs and health information networks. Lacking such standards, providers will not have the data for true coordinated, high-quality, cost-effective healthcare. **ONC needs to specify actions that it will take to advance the development, adoption and use of industry-recognized data definition and data normalization standards, including the implementation and use of vocabularies, code sets, and value sets.**

EHR REPORTING

HHS describes several strategies and offers recommendations about EHR Reporting:

EHR REPORTING
- 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.
    - Recommendation 1: Simplify the scoring model for the Promoting Interoperability performance category.
    - Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.
    - Recommendation 3: Reduce burden of health IT measurement by continuing to improve 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.
    - Recommendation 4: 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.
    - Recommendation 5: Revise program feedback reports to better support clinician needs and improve care.
- Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.
    - Recommendation 1: Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting.
    - Recommendation 2: Adopt additional data standards to makes access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals.
    - Recommendation 3: Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.
- Strategy 3: Improving the value and usability of electronic clinical quality measures while decreasing health care provider burden
    - Recommendation 1: Consider the feasibility of adopting a first-year test reporting approach for newly developed electronic clinical quality measures.
    - Recommendation 2: 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.
    - Recommendation 3: Explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives.

In general, Premier supports the proposed EHR Reporting strategies and recommendations. However, Premier believes that significant challenges remain regarding the promoting interoperability programs and measures; variability in EHR vendor implementation of standards; insufficiencies in interoperability standards; lack of attention to semantic interoperability standards; and inconsistent use of terminologies and formats. Information that is electronically exchanged from one provider to another

should adhere to the same standards, and these standards should be implemented uniformly (within EHRs), for the information to be understandable and usable, thereby enabling interoperability.[1] Premier supports prior and ongoing HHS efforts to align administrative and reporting requirements across programs and we urge HHS to continue work where gaps still exist. For example, additional work is needed to advance data sets, standards and CEHRT criteria. This would go a long way to alleviate differences across EHR platforms and help ensure more consistent EHR implementations.

CMS should allow providers to obtain credit for multiple health IT activities under the CMS Promoting Interoperability Programs. Premier strongly recommends that **CMS identify specific alternatives to the traditional program measures and quickly implement changes to the Health IT measures.** Premier suggests that **at a minimum, the following activities be recognized as advancing interoperability: participation in local, state and/or national HIEs; participation in the Trusted Exchange Framework and Common Agreement (TEFCA); implementation of open APIs; implementation of clinical decision support (CDS) software; implementation of patient portals; and implementation of clinical surveillance and patient safety software and technologies**. Providers and clinicians should be allowed to attest to the use of various health IT functionalities and activities (beyond EHRs) and obtain credit across Promoting Interoperability performance categories. We **emphasize our recommendations that CMS:**

- Allow providers and clinicians greater flexibility under reporting programs, allow alternative approaches and mechanisms, and give credit to providers and clinicians for their use of diverse health information technologies, tools and activities (such as clinical decision support; clinical surveillance; prior authorization, participation in a national, regional and/or state level exchange)) beyond certified EHRs; and
- Reward providers and clinicians who use enhanced capabilities and functionality (i.e., risk stratification, case management, referral management, care coordination, decision support, data analytics, clinical surveillance, registries, enterprise analytics, and patient engagement) beyond their certified EHRs.

Premier urges CMS to develop and issue quality measure specifications that use common EHR terminology/taxonomy. For example, in the Quality Payment Program's Merit-based Incentive Payment System (MIPS) there are 200+ registry measures for which CMS defines the numerator criteria using either CPT II codes or HCPCS "G" codes – neither of which are widely or consistently used by providers as they are not required for billing and not standard codes in EHRs. This requires providers to either map the codes themselves or pay a vendor who offers that service.

Prior to implementing new or revised objectives/measures, CMS should ensure that the measures are field tested and are feasible in all applicable reporting methods. This will help determine if the measure specifications are precise or open to interpretation. In addition, CMS should strengthen oversight of certified technologies' ability to calculate and validate data fidelity regarding data, place, format and level of attribution.

In the same vein of defining quality measures in a way that is compatible with clinical workflow, documentation and EHR design, we urge CMS to examine the documentation requirements and definitions for their quality measures. For example, it is relatively easy to determine that a specific test was performed and to identify the result of that test. However, CMS often issues measures that depend on documentation that confirms that the provider reviewed the results, requiring manual data verification. The measure reporting is burdensome since it cannot be accomplished electronically. **Premier**

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[1] ELECTRONIC HEALTH RECORDS Nonfederal Efforts to Help Achieve Health Information Interoperability
Report to Congressional Requesters. United States Government Accountability Office. September 2015
https://www.gao.gov/assets/680/672585.pdf

recommends that CMS prioritize measures that are captured, collected and calculated electronically, including via tools and technologies such as clinical data registries, and measures that use data for which there are accepted and widely supported and adopted standards.

Premier reiterates our recommendations that CMS should align measures and methodologies across programs to help eliminate redundant reporting. Premier believes that adding measures in the absence of evidence as to their value and feasibility of electronic reporting and calculation is not beneficial and results in additional provider burden.

Application program interfaces (APIs) should be standardized, openly published, and consistently implemented. HHS should designate an open, public API standard(s) for EHRs based on the HL7 FHIR and OAuth standards to ensure consistent and fair market adoption and implementation of open APIs for providers, consumers/patients, and other authorized healthcare stakeholders. The technological solutions and capabilities and public policies (i.e., open APIs) that HHS has focused on to provide patients and consumers access to their health data should be used to ensure data access, availability and exchange across the care continuum (including between providers, employers, payers, community-based organizations or ACOs). Providers must be able to: connect any third-party application of their choosing to their EHR and use third party applications without obtaining "permission" from their EHR vendors.

Open APIs as required under CEHRT should support: provider-and patient-facing applications and the ability to move data into and out of EHRs (read-write capabilities), so that applications can be used within provider workflow. Certified EHR vendors: should be required to publicly disclose all business practices and contractual terms and conditions (such as any and all fees or costs) associated with their platforms' functionality; API development, implementation, access and use; and integration services and capabilities). As required by Cures, ONC should ensure that EHRs are technically capable of transmitting to, receiving and accepting data from registries and other data sources as a condition of certification in accordance with standards recognized by ONC. Furthermore, EHR vendors should demonstrate and attest to their systems'/platforms' interoperability (ability to send data to and receive data from other EHRs and data sources) and conformance to standards (i.e., explicit conformance to FHIR versioning, resources)

Certification should promote high fidelity data to reduce variability across EHRs, bi-directional exchange of information using APIs and timely data to enable interoperability. ONC should enhance the CEHRT program -- CEHRT requirements should ensure that standardized data elements are implemented and supported to populate measures for all the federal reporting programs. Ideally, we believe it is essential that the certified technology be able to calculate the measures. At a minimum, they should be able to seamlessly and reliably produce the required data elements. Premier feels strongly that adding measures in the absence of evidence as to their value and feasibility of electronic capture, reporting and calculation is not practical nor beneficial and will result in additional provider burdens. **Other recommended changes to CEHRT** include:

- Harmonizing and aligning ONC's CEHRT and EHR testing processes with CMS' Promoting Interoperability Program requirements so that CMS requirements are fully supported by CEHRT;
- Requiring EHR vendors to demonstrate their products' ability to meet interoperability and usability requirements in advance of establishing any expectations that providers do so;
- Requiring EHR vendors to disclose how much it will cost to integrate third-party applications into their EHR, including full disclosure of any subscription fees and any other costs that may be accrued or assessed;
- Establishing a clear and defined level of predictability of proposed changes so that stakeholders can plan for and anticipate their implementation; and

- Implementing pilot testing and validation of proposed changes before requiring them.

HHS must consider the availability and adoption of data and interoperability standards along with the readiness and feasibility of adopting available standards and the willingness and ability of EHR vendors to support those standards. Our enthusiasm for achieving nationwide interoperability is tempered by the need for technical, syntactical and sematic interoperability and the need for more ONC and CMS efforts to accelerate current standards development, testing, adoption, implementation and vendor support for interoperability to be fully realized. Such standards efforts are essential pre-requisites to achieving interoperability across the care continuum and healthcare settings.

We recommend that ONC and CMS **place more responsibility on EHR vendors for the development and implementation of standardized interoperable systems (via the CEHRT testing program and the EHR Reporting Program).** In addition, **we suggest that ONC implement more robust conditions and maintenance of certification, testing and surveillance processes** to ensure that EHR vendors demonstrate and report on their systems'/platforms' interoperability (ability to send data to and receive data from other EHRs and data sources) and conformance to standards (i.e., explicit conformance to FHIR versioning, resources).

We **urge ONC to expand and enhance the testing and certification processes for EHRs beyond the initial product submission in order to ensure compliance throughout the life cycle of the product.** Ensuring CEHRT is up to date enables providers to more easily meet CMS and ONC reporting requirements. We caution that new CEHRT versions should be major revisions that address overarching health IT goals and impact storing, collecting and transferring data. Requiring vendors to regularly recertify to new CEHRT versions with minor changes will be a significant financial burden to providers as vendors often pass on recertification costs to providers. Nationwide interoperability requires the development, adoption and consistent implementation of data and interoperability standards, however, EHRs do not uniformly collect, define or present data. A common or core data set is insufficient to achieve interoperability. ONC needs to call for the use of standard clinical terminologies, vocabularies and data formats in addition to agreed-upon data exchange methodologies.

We urge ONC to advance policies (i.e., certification and EHR Reporting criteria) that include specific interoperability standards (transport, syntax, and sematic) along with technical implementation specifications for EHRs. ONC should accelerate efforts that **encourage consistent standards implementation, reduce implementation variability, and improve modularity in health data standards for terminology and vocabulary, coding, data content and format, transport, and security**.[2] Lacking such improvements to the standards, providers will not have the data for true coordinated, high-quality, cost-effective healthcare. **ONC needs to take actions to advance the development, adoption and use of industry-recognized data definitions and data normalization standards,** including the implementation and use of vocabularies, code sets, and value sets. Currently, providers and clinicians are unable to incorporate electronic information received into their EHR due to the limitations of the EHR itself (i.e., incongruent implementation of standards, misaligned standards, semantics, and inconsistent implementation of standards specifications) all hindering data flow and impeding useable and understandable data across EHRs and other health information technologies and systems.

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[2] https://dashboard.healthit.gov/strategic-plan/federal-health-it-strategic-plan-goals.php

PUBLIC HEALTH REPORTING

PUBLIC HEALTH REPORTING

- Strategy 1: Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.
    - Recommendation 1: Federal agencies, in partnership with states, should improve interoperability between health IT and PDMPs through the adoption of common industry standards consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules, to improve timely access to medication histories in PDMPs. States should also leverage funding sources, including but not limited to 100 percent federal Medicaid financing under the SUPPORT for Patients and Communities Act, to facilitate EHR integration with PDMPs using existing standards.
    - Recommendation 2: HHS should increase adoption of electronic prescribing of controlled substances with access to medication history to better inform appropriate prescribing of controlled substances.
- 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.
    - Recommendation 1: HHS should convene key stakeholders, including state public health departments and community health centers, to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms.
    - Recommendation 2: 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.
    - Recommendation 3: HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care.

Healthcare providers, especially those participating in ACOs, bundled payments and other models should be able to access their patients' medical records on substance use— information that is needed for providers to understand the totality of a patient's care needs and provide safe, effective and coordinated treatment. Requiring individual patient consent for access to addiction records from federally funded substance use treatment programs, as current requirements do, is an obstacle to an integrated and coordinated approach to patient care. It also may unknowingly endanger a person's recovery and his or her life. CMS should allow providers to re-disclose substance use data to participant clinicians. And, at minimum, restore the claims where the secondary diagnosis is for substance use, but the principal diagnosis is not, and simply remove that particular substance use diagnosis.

Due to complex regulatory requirements (42.C.F.R. Part 2), Medicare currently does not make records on substance abuse disorder (SUD) available across all the files furnished to providers and researchers regardless of the program. The policy inhibits providers, particularly those in alternative payment models, from being able to make informed clinical decisions, even though they are held accountable for them. Not only are the claims where a principal diagnosis of SUD redacted, but also the claims where a secondary diagnosis of SUD is coded. This policy skews research by systematically removing certain types of claims for a subset of patients and prohibits researchers from doing analyses on the opioid epidemic among other trends.

Moreover, CMS should provide de-identified aggregate data on substance use claims to providers. CMS should consider ways to offer ACOs a point-of-service notification system that would allow them to know when a beneficiary's eligibility is being checked by a provider and a near real-time opportunity to intervene appropriately to coordinate their care, redirect the patient to an appropriate setting, or engage with healthcare providers who may not be participating with the ACO.

In support of optimizing population health management, APMs and value-based care (VBC), Premier continues to advocate for statutory and regulatory reform of 42 CFR Part 2 (Confidentiality of substance use disorder patient records) to make substance use data more readily available to providers who are already subject to HIPAA patient privacy protection regulations. Until Part 2 reform is enacted, Premier again strongly recommends that providers who are engaged in population health management (e.g. ACOs) and that are bound by a data use agreement with CMS, receive complete and identifiable data from CMS about substance use disorder--related diagnoses and services furnished to their assigned beneficiaries by providers to whom Part 2 does not apply.

While CMS has made great strides in promoting access to government data, continued investments in its infrastructure and statutory permissions are needed. All alternative payment model participants should receive at least monthly data reports and files. In order to provide alcohol and substance disorder diagnoses (whether diagnosis or identified comorbidity) in the monthly files provided to ACOs or bundlers, Congress must modernize the underlying statute for 42 CFR Part 2.

Healthcare providers currently have limited access to Medicaid, the Children's Health Insurance Program (CHIP), Veteran's Affairs (VA) and TriCare data. Streamlined and enhanced access to this information would assist healthcare providers with more effectively managing care transitions between state and federal health programs. The web of different state and federal laws should be harmonized to increase clarity and reduce burden on providers. Moreover, the conflicting federal laws should also be aligned and updated to reflect the digital age. Interoperable EHR systems are needed to ensure patient information can be seamlessly shared across providers to improve care outcomes and efficiency.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. The Premier healthcare alliance supports efforts to transform healthcare through the power of data and health IT. It is essential to address ongoing EHR interoperability and EHR usability challenges so that providers can improve care delivery, patient safety and performance, and drive operational efficiencies. Premier shares the vision of achieving nationwide interoperability to enable an interoperable, learning health ecosystem. Central to achieving interoperability is seamless and unencumbered flow of data to providers at the point of care and within workflow. Premier hopes our comments are helpful as you continue to assess and revise regulatory and operational aspects of federal programs and reduce associated clinician and provider burdens.

If you have any questions regarding our comments or need more information, please contact Meryl Bloomrosen, Senior Director, Federal Affairs, at meryl_bloomrosen@premierinc.com or 202.879.8012.

Sincerely,

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance