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January 28, 2019

Don Rucker, M.D.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Resources
330 C St SW, Floor 7 Washington, DC 20201

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

Dear Dr. Rucker:

On behalf of our over 130 member hospitals and integrated health systems located in Wisconsin, the Wisconsin Hospital Association (WHA) appreciates the opportunity to comment on the draft report from the Office of the National Coordinator (ONC) for Health Information Technology (IT) entitled "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs" (the draft ONC Strategy).

In Wisconsin, our member organizations, large and small, urban and rural, provide services well beyond the four walls of a hospital, and those services are provided by physicians, advanced practice nurses, physician assistants, and other non-physician providers. Our membership includes members that operate a full continuum of care that includes not only hospitals, but also clinics, outpatient surgery, including ambulatory surgery centers, long term care, home health and other health care services.

Our members' embrace of coordinated care delivery models and providing care across a continuum of services inside and outside of the hospital has been a key driver in Wisconsin regularly being recognized as a top state for high quality care. With that comprehensive approach to care delivery, our members bring a perspective to regulatory burden across care settings that is often unique compared to other parts of the country.

We Appreciate HHS's Attention to Identifying and Addressing EHR-Related Regulatory Burden

Regulatory burden creates additional cost on the health care system and limits the productivity of health care providers. Wisconsin, like other states, has challenges with having enough physicians to meet the demands for care of our citizens, and regulatory burden directly impacts the amount of clinical care that each physician can provide in one day. For those reasons, meaningfully reducing regulatory burden for physicians and hospitals is of significant importance to Wisconsin hospitals and health systems.

We appreciate ONC's thoughtful approach to identifying EHR-related sources of regulatory burden, and we encourage HHS to continue seek input from the field to identify additional regulatory reforms to reduce EHR-related regulatory burden on organizations, administrators, physicians, and other clinicians when such regulations do not meaningfully improve health care quality, safety and efficiency.

We make several comments below regarding the draft strategy and thank ONC for the opportunity to provide input on this important topic.

CMS regulatory reforms focusing on reducing clinical documentation requirements needs to be a top priority

The draft ONC Strategy correctly identifies clinical documentation requirements stemming from regulatory requirements as a key cause of EHR-related burden and generally identifies the need for regulatory reform. In support of ONC's

conclusion, we further recommend elevating the importance of this recommendation and further offer specific considerations that HHS could take to reduce clinical documentation requirements.

1. *Review, simplify and update regulations and guidance regarding documentation requirements necessary to meet Medicare and Medicaid payment requirements.*

CMS's documentation guidelines for E/M codes have long been identified as outdated and a significant source of physician burden. The 90 page guidelines¹, largely written at a time when paper-based medical records were the norm, do little to support patient care or improve quality and drive unnecessary documentation complexity in the EHR. Updating and simplifying the CMS documentation guidelines for E/M codes needs to be a priority if ONC's goal to leverage the EHR to reduce EHR burden is to be realized in a meaningful way.

While we support updating and simplifying the E/M documentation guidelines, we have concerns with the approach in the 2019 Physician Fee Schedule final rule to simply consolidate E/M codes. As expressed in WHA's comment letter on that rule, simply consolidating E/M codes will financially disadvantage physicians who see a more complex patient panel. Financial modeling conducted by some of our members anticipates losses in the millions of dollars each year due to the consolidation of the E/M codes in the 2019 final rule. These losses will not be offset by the increases in efficiency that are expected due to the reduction in documentation requirements. Further, creating new add-on codes will only serve to negate the efficiencies the rule hopes to achieve with the documentation changes and such add-on codes will not generate enough revenue to offset the losses that will result from the code consolidation.

2. *Revise regulations and/or create regulatory safe harbors that will permit discrete data gathered by the EHR – as opposed to narrative notes - to satisfy CMS payment requirements.*

We agree with ONC's goal to leverage existing and discrete data gathered by the EHR as a means to reduce narrative documentation notes. To achieve this, HHS should review and update its existing regulations and guidance to ensure that such discrete data – particularly data not directly entered by the billing professional – can be used to support billing and regulatory requirements. In addition or as an alternative, HHS should also consider creating regulatory safe harbors that explicitly permit billing professionals to utilize existing and discrete data gathered by the EHR in lieu of a narrative note or data re-entered by the billing professional.

3. *Revisit and revise regulations and guidance that discourages physicians from delegating or incorporating clinical documentation to/from other staff and clinicians.*

Over the years, CMS has promulgated rules and guidance that have required the billing professional to personally sign, attest, or document information, which can result in redundant EHR entries by multiple professionals with little to no clinical benefit. One example, though it has subsequently been eliminated in the physician Quality Payment Program, was the meaningful use requirement for documentation utilizing computerized physician order entry. With the advent of care teams and EHRs, CMS rules should be updated to encourage delegation of and reliance upon documentation by multiple members of a care team in the EHR in order to avoid redundant documentation by the care team and to best ensure that all clinical professionals' skills and time can be best used at the top of their license.

4. *Revisit and revise regulations and guidance to enable and encourage patients to enter data into the EHR and to permit use of such patient generated data to meet CMS documentation requirements for payment.*

Ten years ago, when a customer checked into a flight at an airport the customer had to wait for an available agent at a ticket counter to provide details of their trip, provide payment, print boarding passes, and print luggage tags. The ticket agent received the information orally, entered all of that information into the system and then printed the necessary documents. Now, nearly all of that information is entered into the airline's system by the customer in advance at a kiosk or even on a smart phone. Such "self-service" data entry is also now ubiquitous in retail. By leveraging technology and the ability for customers to enter important information

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>

ahead of time, both airlines and retail have been able to make processes more efficient and reduce time spent by employees doing manual data entry.

CMS should revisit and revise regulations and guidance to similarly enable and encourage patients to enter data into the EHR prior to an encounter and explicitly permit use of such patient generated data to meet CMS documentation requirements for payment. Particularly in primary care, enabling patients to electronically provide information in advance of an encounter through guided and dynamic symptom and history query, and permitting billing professionals to directly incorporate that patient-submitted data into necessary billing documentation, has an opportunity to create similar efficiencies that are now realized in other parts of our economy.

5. *Explore regulatory changes that can create greater standardization of prior authorization processes and reduce associated documentation burdens.*

Wisconsin hospitals and health care providers are increasingly identifying prior authorization documentation burden as a significant source of administrative burden. We agree that HHS can play a role in reducing prior authorization variation and burden not only for Medicare but for other payers as well. We also agree that EHRs and other health IT solutions can mitigate this burden, but that there is a lack of standardization and common approaches that directly contributes to prior authorization related documentation burden.

We are encouraged by ONC's consideration of building upon HIPAA's standardized transaction set regulations that helped to standardize claims processes to create new transaction standards leveraging EHR data to standardize prior authorization exchanges of information. Additional exploration of this public policy proposal by multiple stakeholders will be necessary, however, we believe that the concept of expanding the HIPAA transaction standards to include prior authorizations holds some promise for enabling better leveraging of existing EHR data and reducing manual documentation to fulfill prior authorization requests.

6. *Explore whether CMS text-based documentation requirements necessary for billing could be replaced with non-text based methods of "documentation."*

With the advent of cloud computing, less expensive data storage, less expensive camera technology, and voice recognition, there are opportunities for validating for billing purposes that services were provided that do not depend upon a text narrative created by a health care professional. CMS should explore its regulations now and consider changes that could enable the capture of audio, visual or other data necessary to "document" a patient encounter for billing purposes, and thus free up text documentation time for providers that focuses solely on what information is necessary to include in the EHR record for care continuation and coordination.

CMS should update Medicare Advantage and Medicaid managed care organization rules and contracts to drive commercial payer adoption of clinical documentation simplification and standardization reforms.

The draft ONC Strategy identifies various CMS regulations and guidance that could be changed to directly impact health care providers participating in fee for service Medicare and Medicaid programs, however the ONC Strategy seems to suggest that HHS has less ability to effect EHR related burden issues involving patients with commercial insurance. However, missing from the ONC draft is a recognition that CMS regulations and policies do impact commercial payers, both directly and indirectly.

In particular, we would encourage CMS to also consider changes to Medicare Advantage and Medicaid managed care organization rules that could implement policy changes aimed at reducing EHR-related burden. Making such changes to commercial insurers participating in those programs could lead to voluntary changes for those commercial insurers' non-Medicare and Medicaid plans. In addition, by choice, many commercial plans' technical payment policies default to CMS's technical payment policies if the commercial plan does not specifically address an issue, thus CMS has an ability to further influence commercial plan policies around EHR burden. In either case, CMS has the ability to take the lead in making policy changes that will impact EHR documentation burden for commercial plans as well, and we encourage ONC to consider further recognizing and leveraging that reality in its recommendations.

CMS should continue and accelerate work to reduce EHR-related burden associated with program reporting.

The draft ONC Strategy correctly identifies a need to reduce EHR-related burden associated with program reporting. Unfortunately, most of the focus of building and utilizing EHRs since the advent of the first meaningful use standards has been on building and maintaining an ever-expanding list of reporting requirements. Many of these requirements gave short shrift to considering workflow factors that have made the provision of health care less efficient and more burdensome. Many of the reporting requirements did little to improve care quality or efficiency, and at the same time drained time and financial resources from health care providers and EHR vendors to develop innovative uses of EHR technology to improve the efficient provision of health care. Consistent with the recommendations in the draft ONC Strategy, we encourage CMS to continue and accelerate its work to reduce EHR-related cost and burden associated with program reporting.

We also encourage CMS to consider further flexibility in program reporting that takes into account differing needs of different providers. For some health care providers, there might be an advantage on focusing on granular issues that would justify more detailed or specific reporting. On the other hand, for other health care providers, simpler might be better. We encourage CMS to not take a one size fits all approach to reporting so that health care providers can report data that is truly meaningful for their and their communities' needs.

HHS should take additional steps to encourage innovative design and uses of EHR technology.

We agree with the ONC Strategy that HHS should incentivize innovative uses of health IT that reduce reporting burdens and provide greater value to physicians. Making changes to highly complex EHR systems and patient care workflows come at significant cost and risk to health care providers which deters widespread testing and innovation of EHR technology. We encourage HHS to explore ways to offset that cost and risk through grants and other payments to health care providers that take bold steps to innovate and try something new that holds potential for widespread EHR burden reduction.

The new emphasis on workflow impact in regulatory changes is appreciated.

We appreciate HHS's new focus on how EHR-related regulatory changes impact clinical workflow and recognize ONC's emphasis on considering clinical workflow in future rulemaking. In order for EHR technology to live up to its promise of delivering more efficient health care, regulatory impacts on clinical workflow must be prioritized.

Increase interoperability focus on care delivery systems that lack robust EHR usage and/or are highly fragmented.

As HHS continues to consider options for advancing interoperability, we would encourage them to devote some focus on systems of care that either lack robust EHR infrastructure and/or are highly fragmented. For various reasons, both long term care providers and behavioral health providers – particularly community based behavioral health providers – have significantly lagged in adoption of EHR technology. Further, behavioral health care is often fragmented with multiple types of very small groups of providers that would significantly benefit from being able to exchange information with other providers.

While work is progressing on connecting health care providers with an EHR infrastructure together, little focus has been on connections between providers that have not or have been unable to make investments in EHR technologies. To support a continuum of coordinated care, we would encourage HHS to place new focus on developing a rudimentary infrastructure that could enable such providers to electronically share and receive basic care information with other providers.

Improve standardization and interoperability of public health systems as well as PDMP systems.

We agree with ONC that public health-related activities are known to contribute to administrative burden for physicians and that there is wide variation in program content, format, reporting methodology and in data collection outside the normal clinical workflow. We also agree with ONC's recommendations to harmonize reporting requirements across federally funded programs to establish common standards and reporting requirements in order to reduce data collection and reporting burdens.

Similarly, we would encourage ONC to recommend that federally funded PDMP systems meet interoperability standards to enable those systems to directly exchange information with EHRs that meet the Certified EHR Technology standards. Health care providers have made millions of dollars of investments in their EHRs to meet CEHRT interoperability standards to transmit health care data in a standardized way. Unfortunately, health care providers have found that despite those investments, they cannot directly exchange information with PDMPs without additional workarounds if the PDMP was not also built to accept and transmit health care information utilizing CEHRT interoperability standards. These workarounds can be costly and time consuming to implement for both the health care provider and their EHR vendor as well as the PDMP. Going forward, we would recommend that HHS require federally funded PDMP systems to at a minimum be constructed to meet CEHRT interoperability standards in order to leverage existing investments made to develop and implement interoperable EHRs.

ONC and its partner agencies should develop and advance metrics to monitor the impact of their strategies to reduce clinician EHR burden.

To ensure policies and strategies are achieving their goals and are minimizing or reducing clinician burden, we recommend that ONC develop and use stakeholder-vetted metrics to measure the volume or difficulty of reporting requirements. Without valid and publicly available measures, it will not be clear to government or stakeholders whether its strategies to reduce clinician burden are effective.

Thank you again for the opportunity to comment. If you have any questions, please contact Matthew Stanford at (608) 274-1820 or mstanford@wha.org.

Sincerely,

/s/

Matthew Stanford
General Counsel
Wisconsin Hospital Association, Inc.