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Advancing Health in America

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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 the nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) 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 to of Health IT and EHRs."

In this report required by the 21st Century Cures Act, ONC recommends actions that the Department of Health and Human Services (HHS) and other stakeholders can take to reduce burden on physicians, other clinical staff, hospitals, and other provider organizations from documenting clinical information in electronic health records (EHRs) and meeting regulatory reporting requirements. The report also recommends ways to improve health IT usability and the user experience. **The AHA greatly appreciates the attention ONC has paid to reducing excessive burden and offers the following detailed comments on the recommendations in the draft report.**

## CLINICAL DOCUMENTATION

**Documentation burden**. The AHA appreciates ONC's recognition of the double-edged sword providers encounter in their use of health IT and EHRs, namely that these technologies support care delivery, but also can increase the burden of providing and documenting care. We support ONC in its efforts to reduce EHR-related burden while simultaneously optimizing the usefulness of EHRs for patient care and reducing the contribution of IT tools to physician burnout. The agency focuses particularly on

addressing documentation and reporting requirements and EHR functionality that have resulted in excessive documentation or "note bloat." The AHA believes that these efforts to modernize documentation platforms and requirements are essential to ensuring health IT and EHRs support the advancement of patient care. We also believe that improving the ability for clinicians to use EHRs to communicate with one another is vital to high-value patient care, and we encourage ONC to consider ways to ease provider-to-provider communication.

The AHA agrees that reducing overall evaluation and management (E/M) documentation burden also could reduce EHR-related burden. However, we urge ONC and its partner agencies, such as the Centers for Medicare & Medicaid Services (CMS), to continue to explore changes specific to EHR documentation that go beyond high-level changes to E/M documentation, as well as documentation requirements applicable to provision of care other than E/M visits, including care that is delivered via telehealth.

**In our comments on the calendar year (CY) 2019 physician fee schedule (PFS) proposed rule, we expressed our support for CMS's efforts to free providers from requirements to produce repetitive documentation and enable them to focus on the issues that are most pertinent to patient care.** We also support ONC's strategies to reduce overall regulatory burden around documentation of patient encounters and reduce re-documentation in clinical notes. These strategies should target both nursing and physician documentation, with the goal of reducing duplication and improving communication.

However, we continue to believe that the policy CMS finalized to default to level 2 E/M visit documentation requirements in CY 2021 (when the blended payment rate for levels 2 through 4 visits go into effect) will not have a meaningful impact on providers' availability to spend time with patients. Specifically, providers still will need to document detailed information about resource use and intensity of services to meet other Medicare requirements, the requirements of other payers, and various legal requirements, as well as to succeed in certain value-based care programs. Therefore, they are unlikely to relax documentation practices across their patient populations.

In our comments on the PFS rule we also encouraged CMS to engage in a broader effort to understand and implement proposals that would reduce providers' documentation burden in a meaningful way, such that providers have more time to spend with patients. **Therefore, we support ONC's recommendation to obtain ongoing stakeholder input into updates to documentation requirements. We recommend, however, that any task force or other mechanism to gather stakeholder input be composed of a range of viewpoints (providers, vendors and payers), but include a majority of participants from the clinical community, hospitals and health systems.**

Finally, in its efforts to promote best practices, we encourage ONC and partner agencies, such as CMS, to rethink documentation requirements and evaluate whether

certain requirements should be eliminated rather than modified in order to make documentation more efficient for providers. To support this approach, ONC could work with EHR vendors to evaluate the extent to which providers actually access and use existing required documentation for clinical care after entry into the record, as a guide to determine what might be extraneous.

**Furthermore, new requirements must be evaluated for their impact on burden.** For example, the new requirements on use of Appropriate Use Criteria (AUC) for ordering of advanced diagnostic imaging tests impose significant burdens on both ordering and furnishing professionals and furnishing facilities, including documentation that approved AUC tools were consulted. The AHA remains opposed to requirements that furnishing professionals and facilities include documentation on their own claims that the ordering professional consulted AUC tools.

**Prior authorization (PA). We commend ONC's focus on reducing the administrative burden of PA and the agency's recognition that the PA process lacks standardization and suffers from limited automation due to lack of an adopted health care standard for claims attachments.** Our member organizations see firsthand the burdens that come from these manual and labor-intensive processes, as well as the unnecessary, and sometimes unwise, delays and changes in patient care that can result.

We want to clarify, however, that health care standards for claims attachments and PA already are in place:

- The X12 Standard for Electronic Data Interchange (EDI) Health Care Services Review-Request for Review and Response (278) for prior authorization requests has been fully developed and named by HHS as an official administrative transaction standard under the Health Insurance Portability and Accountability Act (HIPAA).
- The X12 Standard for Additional Information to Support a Health Care Services Review (275) has been fully developed as a claims attachment, but has yet to be named by HHS as an official HIPAA standard.

Unfortunately, according to the 2018 CAQH Index Report, current industry usage of the X12 278 standard for prior authorization is low, at 12 percent, even though it is the second most costly transaction when completed manually at $7.28 per transaction. In contrast, the health care field has reached 96 percent adoption of the standard for electronic claims submission (X12 837). If we could achieve full adoption of just six of the electronic transactions approved under HIPAA, the health care sector could save more than $9.8 billion in direct administrative costs annually.

**AHA supports ONC's recommendation to adopt standardized templates, data elements and real-time standards-based electronic transactions to improve automation around these processes. However, we believe some of the proposed**

**recommendations could have unintended consequences for adoption of the current standards and the stakeholders that use them.** Specifically, we are concerned about the recommendation to advance new standards without full consideration of the adoption path for the existing standards (X12 278 and X12 837). Indeed, it is unclear whether these standards were even evaluated as a part of these recommendations.

**ONC must build on existing work by first thoroughly reviewing the current standards and including these in ongoing discussions so that the agency does not compromise the work done to develop the HIPAA-mandated transactions for prior authorization and claims attachment or the stakeholders who use them.**

We also are encouraged by the steps ONC has taken to include key stakeholders in outreach and engagement in this process and agree that HHS must work closely with stakeholders to expand their work and to coordinate efforts to improve the PA process. However, we are concerned that HHS's recommendation does not include the standard development and data content organizations currently engaged in standardizing administrative transactions. These include the American National Standards Institute accredited standards development organizations – ASC X12, Health Level 7 and National Council for Prescription Drug Programs, as well as the National Uniform Claim Committee, the National Uniform Billing Committee, and the Dental Content Committee of the American Dental Association. These organizations provide a broad perspective on institutional and professional data reporting and needs and promote the development of uniform electronic administrative transaction standards to and from all third-party payers. As such, we believe these organizations are integral to improving administration transactions and excluding them could inadvertently create duplication or disruption of existing efforts.

**Finally, while we agree with and support the need for standardized data and processes, we are concerned that ONC's recommendation to advance new standards to support prior authorization does not adequately address the issues around broadly applied prior authorization programs that impose significant administrative burdens on all health care providers.** Today, there is significant variation between utilization review entities' prior authorization criteria and requirements in addition to the extensive use of proprietary forms. This lack of standardization places significant administrative burden on providers, who must identify and comply with each entity's unique requirements. While there is a need to support more automation around these processes, it will not address the lack of transparency or uniformity around payer requirements for prior authorization.

The AHA strongly recommends that HHS expand its work with clinicians, payers, medical product manufacturers and health IT developers on ordering services and PA processes to include a focus on bringing standardization to both the process and the information required by utilization programs. All stakeholders also should consider how

to reduce the need for prior authorization, particularly as we improve documentation and move to new models of care that put more financial risk on providers.

Both a fundamental transformation that encourages standardization of PA criteria across utilization review entities and standardized electronic communication and transfer of information are needed to promote uniformity and enable timely, transparent, and simplified communication between key stakeholders. We are encouraged that ONC recognizes this need and stand ready to participate in continued efforts to reduce burden in this area.

**REPORTING REQUIREMENTS**

**The AHA greatly appreciates the attention to reducing the burden of reporting under the Promoting Interoperability Program (PIP), Merit-based Incentive Payment System (MIPS) and the Medicare Inpatient Quality Reporting program.** As noted in our comment letter on the FY 2019 inpatient prospective payment system (PPS) rule, hospitals and health systems welcome the greater flexibility, reduced reporting burden, and better alignment of the PIP requirements across hospitals and clinicians that has been introduced by CMS. We look forward to additional streamlining in the future.

**Unfortunately, we continue to see differences in clinician requirements across the Medicare and Medicaid PIP programs, and urge HHS to take steps to align the Medicaid program with the Medicare requirements.** The lack of alignment is particularly acute in 2019, when Medicaid programs will use more rigid, historical meaningful use criteria, while Medicare has shifted to the more flexible PIP approach. All providers, and particularly multi-state systems, experience significant burden tracking and complying with varying requirements for reporting across hospitals, clinicians and states.

**We also encourage HHS to make improvements to the usability and performance of reporting systems that clinicians, hospitals and health systems use to report data, such as QualityNet**. The systems can be hard to understand and often are overloaded, slow or even unavailable close to the deadline for reporting. AHA members report hiring additional staff and assigning overtime hours to accommodate system slowdowns or to enter reports after hours, when systems are more responsive. Members also report burdensome systems for enrolling staff and maintaining privileges for accessing systems that include things like the use of wet signatures and monthly password changes for staff who only submit reports annually. Particularly for health systems with centralized reporting structures, the process to log onto systems designed for single hospital attestation by one end user such as QualityNet, requires staff to regularly update and track login information – even when no attestation is being made, using valuable staff time and resources.

**Electronic clinical quality measures (eCQMs). We applaud CMS for continuing to evaluate the current landscape and future direction of eCQMs.** We urge the agency to continue to engage those who must report the data in this activity. We strongly agree that any newly-adopted eCQMs be introduced with a testing period and recommend a two-year test period so that providers can understand their performance and implement strategy to improve performance before the results are included in public reporting or payment programs. Furthermore, CMS should adopt only measures that have been tested as electronic measures and received endorsement by the National Quality Forum. Consistent with CMS's meaningful measures initiative, only a small set of important, valid and feasible measures should be required. And, measures should be continuously evaluated for their value and removed if they no longer serve a clear purpose. The variability of reporting requirements across payers also adds to clinician burden. As a major payer, we urge CMS to work with providers and other payers to standardize and streamline quality reporting requirements across payers.

**We also believe that ONC should improve its certification requirements for eCQMs to be more robust, resulting in systems that generate meaningful data with less effort. Furthermore, EHR vendors should be required to certify against all eCQMs, and not just those of the vendors' choice.** Otherwise, providers cannot themselves choose what measures to report without paying additional fees.

**Public health reporting.** The agency identifies a real challenge to public health reporting: variation across states in ability to receive data. To address this issue, **we urge HHS to support states in growing their capability to receive data and adhere to the technical standards included in certified EHRs.**

**We also urge HHS to recognize the need to better standardize and connect prescription drug monitoring programs across state lines.** As noted in our comment letter on the FY 2019 inpatient PPS proposed rule, the AHA strongly supports the intent to use the health IT infrastructure to provide insight on Schedule II opioid prescribing practices. However, in addition to variation across states, Prescription Drug Monitoring Programs (PDMPs) generally are not easily integrated into EHRs, and access fees can be high. We urge ONC to work with PDMPs to improve integration into EHRs and sharing of data across states. We also urge ONC to consider the use of an open, standard application programming interface by PDMPs to enable a provider's EHR to access the Schedule II opioid prescription drug history of a patient.

## HEALTH IT USABILITY AND THE USER EXPERIENCE

**The AHA appreciates ONC's focus on improving the usability of health IT and the user experience.** AHA members report that clinical teams – including physicians, nurses and other clinicians – routinely experience lack of usability. For example, many report changing their clinical workflows to accommodate the EHR, rather than having EHRs that support their optimal clinical workflow. More attention to usability, deployment of quality design principles and user-centered design is needed.

**We disagree, however, with the recommendation that health care providers increase their budgets for ongoing training.** While training is clearly essential, and must be funded, usable systems developed according to user-centered design principles should be intuitive and facilitate both rapid onboarding and ease acculturation to changes in the software.

In addition to considerations specific to the technology, we also would point to the interaction between reporting and documentation requirements, certification requirements and usability. Excessive regulatory requirements can result in design choices that are less usable than they might otherwise be.

Furthermore, the move to value means that health care providers will need more than clinical data to engage in population health and other activities. **Therefore, usable systems will need to connect to information on social determinants, behavioral health, pharmacy benefit data, durable medical equipment, claims history and other relevant data.**

**Interoperability. Lack of interoperability is a factor in poor usability.** Therefore, we urge ONC to continue moving forward to build capacity to share information efficiently and effectively. This also will require addressing how shared information can be managed and parsed to find the relevant information. At the moment, hospitals are routinely sharing care summaries, and physicians and other clinicians increasingly do so. However, as the ones receiving the data, clinicians indicate that the summaries are not easy to use, and pertinent data, such as results of a colonoscopy, must be incorporated into the EHR manually. In addition, redundant information often is contained in the multiple summaries received, leading to even greater "note bloat" and challenges finding relevant information. Other technologies, such as machine learning, natural language processing, and artificial intelligence show promise and should be explored as ways to address these challenges and improve usability overall.

For more on interoperability, we encourage ONC to consider the pathways to interoperability described in our recent report with six other national hospital associations: Sharing Data, Saving Lives: The Hospital Agenda for Interoperability. Making progress will require cooperation across all stakeholders, including government.

**MEASUREMENT**

**The AHA strongly recommends that ONC and its partner agencies develop metrics to monitor the impact of their strategies to reduce clinician burden.** Without valid measures that are publically available, it will not be clear to government or stakeholders whether the strategies are working. Measures could include use of data from vendors, metrics on the volume or difficulty of reporting requirements, or other approaches to understanding the impact of specific strategies. Some of this reporting could be included in the forthcoming EHR Reporting program that ONC is developing

under the 21st Century Cures Act. Please see the AHA's comments on that program for more details.

In conclusion, we congratulate ONC and its partner agencies on their work to reduce the burden of health IT for providers and stand ready to work with the agency moving forward. If you have any questions, please do not hesitate to contact me at cworzala@aha.org.

Sincerely,

/s/

Chantal Worzala
Vice President
Health Information and Policy Operations