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How Healthcare Gets Connected™

May 29, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G – Hubert Humphrey Building
200 Independence Avenue, SW
Washington DC, 20201

RE: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3

Dear Mr. Slavitt:

Thank you for the opportunity to provide comments on the Notice of Proposed Rule Making (NPRM) titled, "Medicare and Medicaid Programs; Electronic Health Record (EHR) Incentive Program-Stage 3." We applaud this effort to simplify the incentive program in a manner that will advance our shared goal of delivering better care to patients while lowering costs to the health care system.

Surescripts operates the nation's largest interoperable clinical health information network. We serve providers and patients in all 50 states and the District of Columbia and deliver over 700,000 clinical health transactions every hour. Every day, more than 70 percent of all office-based providers use our services on behalf of 3 million patients. We connect to 99 percent of all retail chain pharmacies in the country and we delivered over 1 billion prescriptions and 1 billion medication histories to providers this past year. Our provider directory contains over 900,000 prescribers and our Master Patient Index covers 270 million insured lives.

Attached are our comments on four of the eight proposed objectives addressed in the proposed rule. We have limited our comments to those items we can address based on our learning and experience building and operating a national interoperable network. It has been our privilege to collaborate with the Centers for Medicare and Medicaid Services over the past decade as we have implemented the MIPPA and HITECH programs and we look forward to continuing our work with you over the coming years.

Sincerely,

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EVP, Chief Administrative & Legal Officer

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Proposed Objective 1: Protect Patient Health Information

Entities must annually conduct or review a security risk analysis to assess whether the technical, administrative, and physical safeguards and risk management strategies are sufficient to reduce the potential risks and vulnerabilities to the confidentiality, availability, and integrity of ePHI created by or maintained in CEHRT.

We support the proposed objective and measurement and commend CMS for addressing questions raised by the provider community about the relationship between the HIPAA privacy and security rules and the requirements of this meaningful use objective.

We do suggest that before finalizing the rule, CMS clarify the meaning of the proposal that "any security updates and deficiencies should be included in the provider's risk management process and implemented or corrected as dictated by that process." Specifically, we seek clarification regarding whether the corrective action must be implemented by the end of the EHR reporting period, or whether it must simply be identified and described in the entity's plan.

Finally, we also note that the "audit log" referred to could also be seen as already required by HIPAA in order for an entity to comply with the accounting of disclosure requirement. Operating an EHR without that capability would seem inadvisable if an entity hopes to be able to comply with the accounting rule.

Proposed Objective 2: Electronic Prescribing

Eligible Providers must generate and transmit permissible prescriptions electronically, and eligible hospitals and CAHs must generate and transmit permissible discharge prescriptions electronically.

- ***For EPs, more than 80% of permissible prescriptions are queried for drug formula and transmitted electronically using CEHRT.***
- ***For hospitals and CAHs, more than 25% of hospital discharge medication orders for new and changed prescriptions are queried for formulary and transmitted electronically using CEHRT.***
- ***OTC medicines not included in the definition of a prescription.***

We strongly support the proposed 80% threshold for EPs as well as the proposed modification to allow for inclusion of scheduled drugs where controlled substances are permitted to be electronically prescribed. We also concur with CMS's conclusion that the rapid pace of e-Prescribing adoption and utilization among providers suggests that providers be encouraged to meet higher threshold targets.

We also note that as of April 2015, 49 states have established regulations in support of electronic prescribing of controlled substances (EPCS) and 75 per cent of pharmacies nationwide have become enabled to receive EPCS messages.

We also support the 25% threshold for hospitals and CAHs. As is the case with the measure for EPs, we concur with CMS's conclusion that utilization rates for routing and drug formula queries, both of which are supported by the Surescripts network, are increasing at a significant pace, sufficient to support this threshold.

The proposed measure for hospital performance would limit the definition of medication orders to only new and changed prescriptions, and exclude refill orders from the definition. We recommend that CMS evaluate some of the workflow issues related to this definition prior to finalizing the rule. In particular, clarification is required regarding the following questions:

- Is there an implied expectation for the hospital to manage "all prescriptions" during a hospital stay? If so, would this not suggest that refills for medications prescribed previous to admission would be ordered by hospital staff as needed, as opposed to depending on the outpatient prescriber to assume responsibility for that task? On a related note, should hospitals be "authorized" to order refills for orders placed before admission? How will decisions by hospital staff regarding suspending medications due for refill be communicated to pharmacy? This is relevant to workflow since refill request messages are sent from the pharmacy to the originating prescriber. And if the hospital is requesting a refill, will that signal the pharmacy that the subsequent refill request be sent to the hospital rather than the original prescriber?

- How will providers determine the responsible party for managing refills? We suggest that the determination be made based upon when the patient would need a refill; whether the care is still being managed by the hospital post-discharge or when care is transitioned to the primary care or specialist providers; and by the provider managing patient and corresponding medications.

Finally, we concur with the proposal that OTC medications not be included in the definition of a prescription.

Proposed Objective (7) Health Information Exchange

The EP, hospital or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of certified EHR technology. Three measures are proposed for this objective. Providers must submit numerators for each but must meet thresholds for only two of the three.

Regarding Measure 1, that 50% of Transitions of Care be transmitted electronically, Surescripts supports the provisions:

- that a summary of care document should be sent, even if the receiving EP, hospital, or CAH has access to the document through other mechanisms. In our experience, there is value in the "alert" provided by receipt of the summary of care.

- that specifies use of the Common Clinical Data Set (CCDS). EHR workflow can be optimized if there is further specification around the set of data that can be expected upon receipt of a clinical summary.

- that providers include data items they believe to be pertinent and relevant to the patient's care, rather than a list of all problems that have ever populated the problem list. In working with our customers, we have encountered complaints that the summary of care documents contain what is effectively a longitudinal patient record. To drive continued adoption and value in the exchange of summary of care documents, it is important to ensure that only clinically relevant information be included.

Regarding Measure 2, that for 40% of transitions and referrals created by an EP, hospital, or CAH a summary of care record be included and be exchanged electronically.

We believe this measure is critically important. One weakness of MU2 was requiring transmission but not receipt of summary of care documents. Consequently, workflows for sending documents were optimized, but workflows for receiving documents were not.

Surescripts also supports continuing to require particular transport mechanisms. The industry has seen dramatic adoption of Direct Messaging, and we are encouraged by the number of non-TOC use cases that are starting to take advantage of the standard. This would not happen without the adoption triggered by MU2. That said, there

should be some latitude in the final rule to allow for new standards, such as FHIR, to be supported in future as an acceptable transport mechanism.

Finally, we recommend adding guidance on how best to support unstructured documents as part of these transmissions. We have seen a large number of unstructured documents transmitted by our customers (as supplementary materials to the summary of care document), and they are not consistently represented in the message. The Unstructured C-CDA is a common standard used, but additional options exist.

CMS Objective (8) Public Health and Clinical Data Registry Reporting

The EP, hospital or CAH is in active engagement with a PHA or CDR to submit electronic public health data in a meaningful way using certified EHR technology , except where prohibited , and in accordance with applicable law and practice. There are six measures for the objective. EPs are required to successfully attest any 3 of the first 5 measures. Hospitals and CAHs would be required to attest to any combination of four measures. Measures include: (1) Immunization Registry Reporting; (2) Syndromic Surveillance Reporting; (3) Case Reporting; (4) Public Health Registry Reporting; (5) Clinical Data Registry Reporting; (6) Electronic Reportable Laboratory Results.

Regarding the requirement for bidirectional messaging, we note the following concerns:

- There is no systematic way to query a patient's immunization record beyond their local IIS system. A local query will provide an incomplete view for many patients. (Few people live their entire life in one IIS jurisdiction.) A meaningful query needs to identify patients and query multiple IIS systems on a national level.

- Managing individual IIS-level provider credentials with varied testing requirements, etc. makes manual queries across multiple IIS systems a major challenge for users and vendors. A national IIS security/trust framework is needed.

- Lack of a reliable and consistent means to identify and correlate patient data remains a major problem. Given the aforementioned issues, it's unlikely that implementing Query will produce the expected public health benefits. This mandate will essentially force vendors and users to implement a disjointed system with limited value.

Regarding current capacity of state and local registries to meet ONC/CDC standards: Our experience is that state/local registries' have been unable to implement and adhere to the existing ONC/CDC-recommended reporting and transmission standards. We recommend development of a prior agreement on a uniform implementation approach and a universal mandate/incentive/agreement for the state registries to use it.