May 30, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
202 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Re: CMS-9115-P, Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally-Facilitated Exchanges and Health Care Providers

Dear Administrator Verma,

The Medical Group Management Association (MGMA) is pleased to submit the following response to the Centers for Medicare & Medicaid Services' (CMS') proposed rule seeking to improve the nation's healthcare delivery system by increasing interoperability and patient access to health information and meeting the requirements outlined in the bipartisan 21st Century Cures Act (Cures Act). Improving access to information will assist both clinicians and patients make informed healthcare decisions. We applaud the agency for recognizing the need to improve interoperability as well as increase access to health care information and for seeking stakeholder feedback on how best this can be accomplished.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures and specialties that deliver almost half of the healthcare in the United States.

CMS has proposed an extremely ambitious set of requirements on physician practices and health IT developers. We support many of the Administration's health IT goals, particularly putting patients more at the center of the care delivery process and arming them with the health information they need. Our hope is that interoperability, if appropriately implemented, will permit physician practices and other care providers to gain quicker access to more accurate and pertinent patient information. MGMA appreciates the intent of the CMS Proposed Rule and the promise that health IT offers physician practices. However, as Senate Health, Education, Labor and Pensions Committee Chairman Lamar Alexander reminded the Administration at the May 7 hearing *Implementation of the 21st Century Cures Act: Making Electronic Health Information Available to Patients and Providers, Part II*, "…if you play it a little slower, you're less likely to make a mistake." We urge ONC to avoid pushing physician practices too far, too fast. The risks of moving too quickly include additional administrative and financial burdens on practices, weaker privacy and security protections for of sensitive health information, an increased level of physician burnout, and even the potential of compromised patient care.

Summary of Key Recommendations

- **Support for ADT notifications**. MGMA supports requiring hospitals to transmit electronic notifications of patient's admission, discharge, and/or transfer (ADT) to physician practices, other care providers, and other appropriate entities, including Accountable Care Organizations (ACOs).

- **ACOs to receive ADT notifications.** MGMA urges CMS to clarify that ACOs representing providers are entitled to receive ADT notifications.

- **Reasonable certainty standard for hospitals**. MGMA concurs with the requirement that hospitals must have a "reasonable certainty" the patient's community provider can receive an ADT notification.

- **Intermediaries permitted to transmit ADT notifications**. CMS may deem a hospital compliant if they send the ADT alerts to an intermediary such as a Health Information Exchange for distribution to their provider networks.

- **Offer multiple ADT notification transmission options**. MGMA recommends hospitals have multiple options to comply with the proposed ADT notification requirement so they may pick the best option for working with their community providers. As the process of sending ADT notifications matures, work may need to be undertaken by standards-setting bodies like HL7, convened by ONC, to develop a more robust standard that would support the sharing of additional data points, including those outlined by CMS in the proposed rule.

- **Align ADT notifications with information blocking**. MGMA recommends CMS work closely with ONC to align the ADT requirement with the information blocking component of the ONC regulation.

- **Do not include information blocking attestation data on the Physicians Compare website**. MGMA opposes the CMS proposal to include an indicator on Physician Compare for the eligible clinicians and groups that submit a ''no'' response to any of the three information blocking statements.

- **Do not include digital contact information on the Physicians Compare website**. MGMA opposes CMS including an indicator on Physician Compare that a provider does not have a digital contact as this could be misunderstood by patients as suggesting the provider offers sub-par healthcare services.

- **Patient matching request for information.** Accurate patient matching is critical if physician practices are to rely on the data transmitted to them. To improve patient matching, MGMA recommends CMS support the standardization of demographic data, including applying the U.S. Postal Service Standard to the address field. We also encourage exploring the use of email address as an additional patient matching element.

Comments on Specific Provisions of the Proposed Rule

Open API Proposal for MA, Medicaid, CHIP, and QHP Issuers in FFEs

CMS Proposal (7628)

Under our proposal, the scope and volume of the information to be provided or made accessible through the open API would include: Adjudicated claims (including cost); encounters with capitated providers; provider remittances; enrollee cost-sharing; and clinical data, including laboratory results (where available). We propose that these programs and organizations, with the exception of the QHP issuers in FFEs, would also be required to make information regarding provider directories and formularies available through the open API.

MGMA Response

We support patient access to health plan data including adjudicated claims (including cost); encounters with capitated providers; provider remittances; enrollee cost-sharing; and clinical data, including, where available, laboratory results. We also support patient access, through open APIs, to provider directories and formularies. We recommend, however, that CMS work with provider and payer organizations and other impacted stakeholders in developing processes to capture and share these data. In particular, provider directory data has proven to be problematic in terms of accuracy and timeliness of updates. Patients will not benefit if they have faster access to incorrect information. CMS should work with stakeholders to identify opportunities to improve the accuracy of directory data and the speed at which it is collected.

Patient Claims and Encounter Data

CMS Proposal (7632)

We propose that MA organizations, Medicaid and CHIP FFS programs, Medicaid managed care plans, CHIP managed care entities, and QHP issuers in FFEs, permit third-party applications to retrieve, with the approval of an enrollee, certain specific data: adjudicated claims data, including provider remittances and beneficiary or enrollee cost-sharing data; encounters from capitated providers; and clinical data, including laboratory results (but only if managed by the payer). Adjudicated claims data would include on approved and denied claims; under this proposal, adjudicated claims data includes that for which the plan has made an initial payment decision even when the period during which an enrollee can file an appeal is still in effect, or when the enrollee has filed an appeal and is awaiting a reconsideration decision. We specifically request comments from plans regarding the feasibility of including such claims data, including any possible timing issues. In addition, the open APIs required for these entities must make available formulary information (for MA–PD plans) or information about covered outpatient drugs and preferred drug lists (for state Medicaid and CHIP agencies, Medicaid managed care plans and CHIP managed care entities).

MGMA Response

The Proposed Rule would require payers to share EHI with third party applications of a patient's choice through new, innovative APIs that utilize the FHIR protocol. These third-party application developers, which are entering the healthcare market at a rapid pace, are typically not required to abide by the provisions in HIPAA due to the fact they offer their applications directly to consumers and not on behalf of covered entities such as providers or health plans. It is imperative that CMS develop an approach for how practices and other entities that are, for the most part, covered entities or business associates and thus subject to HIPAA, share EHI with these non-HIPAA

entities, and ensure that such third-party applications are equipped to handle patient information. CMS should provide guidance on the types of "verification" that will be permitted and permit payers to undertake some form of review of third-party applications themselves before permitting them to connect to their APIs.

Further, CMS, ONC, and OCR should engage with the private sector in the development of a privacy and security trust or certification framework for third-party applications seeking to connect to APIs. Once established, CMS should permit payers to limit the use of their APIs to third-party applications that have agreed to abide by the framework. Such a program would not only foster innovation, but also establish improved assurance to patients of the security of their information.

Provider Directory Data

CMS Proposal (7633)

We are also proposing at 42 CFR 422.119(b)(1)(iii), 431.60(b)(3), 438.242(b)(6)(ii), 457.730(b)(3), and 457.1233(d)(2)(ii) that the required API make available provider directory data, including updates to such data. Our proposal at 45 CFR 156.221 would not require QHP issuers to permit third party retrieval of provider directory and preferred drug list information because such information is already required to be provided by QHPs in FFEs. For MA organizations, at proposed 42 CFR 422.119(b)(1)(iii), we propose to specify that MA organizations make specific provider directory information for their network of contracted providers accessible through their APIs: The names of providers; addresses; phone numbers; and specialty. This information is the same information MA organizations are already required to disclose to their enrollees under 42 CFR 422.111(b)(3) and make available online under 42 CFR 422.111(h)(2)(ii). MA organizations would be required to ensure the availability of this information through their APIs for all MA plans. Including this information in an open API allows non- MA third-party applications to consume, aggregate, and display plan data in different contexts, allowing patients to understand and compare plan information in a way that can best serve their individual needs. MA plans would be required to update provider directory information available through the API no later than 30 calendar days after changes to the provider directory are made.

MGMA Response

As stated above, we recommend that CMS work with provider and payer organizations and other impacted stakeholders in developing processes to capture and share these data. In particular, provider directory data has proven to be problematic in terms of accuracy and timeliness of updates. Patients will not benefit if they have faster access to incorrect information. CMS should work with stakeholders to identify opportunities to improve the accuracy of directory data and the speed at which it is collected.

CMS proposes MA plans would be required to update provider directory information available through the API no later than 30 calendar days after changes to the provider directory are made. This timeframe may be overly ambitious, and we urge the agency to consult with impacted stakeholders on the 30 calendar day requirement.

Public Reporting and Prevention of Information Blocking on Physician Compare

CMS Proposal (7647)

We believe it would benefit the public to know if eligible clinicians have attested negatively to the statements under 42 CFR 414.1375(b)(3)(ii) as this may assist the patient in selecting a clinician

or group who collaborates with other clinicians, groups, or other types of health care providers by sharing information electronically, and does not withhold information that may result in better care. Therefore, we are proposing to include an indicator on Physician Compare for the eligible clinicians and groups that submit a ''no'' response to any of the three statements under 42 CFR 414.1375(b)(3)(ii)(A) through (C). In the event that these statements are left blank, that is, a ''yes'' or a ''no'' response is not submitted, the attestations would be considered incomplete, and we would not include an indicator on Physician Compare. We also propose to post this indicator on Physician Compare, either on the profile pages or the downloadable database, as feasible and appropriate, starting with the 2019 performance period data available for public reporting starting in late 2020.

MGMA Response

We have concerns regarding how CMS is proposing to include an indicator on Physician Compare for the eligible clinicians and groups that submit a ''no'' response to any of the three statements under 42 CFR 414.1375(b)(3)(ii)(A) through (C). By publicizing the fact that a provider submitted a "no" response, the agency appears to be equating this with the quality of the healthcare they deliver. We believe this is the wrong approach for the agency to take. There could be multiple reasons for a provider stating that information had been blocked, including a misunderstanding of the attestation. For example, Statement Two focuses on how a practice implemented their CEHRT. The clinician may believe that due to the fact that the practice declined to purchase expensive interface software they are required to say they "blocked" information. With no context provided to the patient for why the clinician stated "no" the patient may be left with the impression that the provider is somehow sub-par and should not be trusted.

In addition, MGMA continues to receive reports of inaccuracies despite practices' multiple attempts to correct the information on their end, as well as complaints related to certain features that are unaddressed by the proposed rule. Inaccuracies are also a reoccurring and frustrating problem for practices that struggle with both the administrative hassles of correcting the misinformation and addressing any undue harm to their reputation. Inaccurate or misleading information would likely confuse beneficiaries and be more harmful to beneficiaries and providers than no information.

For these reasons, we oppose including an indicator on Physician Compare for the eligible clinicians and groups that submit a ''no'' response to any of the three statements under 42 CFR 414.1375(b)(3)(ii)(A) through (C). Should CMS move forward with this proposal, prior to implementing this punitive approach, we recommend CMS conduct a minimum of a two-year educational campaign offering additional clarification for providers and give those providers who stated "no" the opportunity to re-attest.

Proposed Public Reporting of Missing Digital Contact Information

CMS Proposal (7649)

We propose to increase the number of providers with valid and current digital contact information available through NPPES by publicly reporting the names and NPIs of those providers who do not have digital contact information included in the NPPES system. We propose to begin this public reporting in the second half of 2020, to allow individuals and facilities time to review their records in NPPES and update the system with appropriate digital contact information. We are also requesting comment from stakeholders on the most appropriate way to pursue this public reporting initiative, including where these names should be posted, with what frequency, and any other information stakeholders believe would be helpful.

MGMA Response

While we support the inclusion of valid and current provider digital contact information available through NPPES, we have concerns with how CMS is proposing to make information in the NPPES transparent. By publicizing the fact that a provider does not have their digital contact information listed in the NPPES, the agency appears to be equating a provider having or not having digital contact information with the quality of the healthcare they deliver. We contend this is the wrong approach. Without providing context to the patient regarding why or why not a provider has their digital contact information listed, the patient may be left with the impression that the provider who does not have their digital contact information listed is somehow sub-par and should not be trusted.

For these reasons, we oppose including an indicator on Physician Compare that a provider does not have digital contact information. Should CMS move forward with implementing this punitive approach, we recommend CMS conduct a minimum of a two-year educational campaign aimed at encouraging providers who have not yet had their digital contact information listed in the NPPES to do so.

Admission, Discharge, and Transfer Notifications

CMS Proposal (Pages 7650-7652)

CMS proposes to require Medicare- and Medicaid-participating hospitals and Critical Access Hospitals that utilize electronic health records (EHR) systems to send electronic notifications of patient's admission, discharge, and/or transfer (ADT) to another health care facility or another community provider. The notification must contain "minimum patient health information" and could be sent through an intermediary, like a health information exchange (HIE), or directly to community providers. The notifications would be required immediately prior to or at the time of the patient's discharge or transfer from the hospital. A hospital would only need to send notifications to those practitioners who have an "established care relationship" with the patient relevant to his or her care and for whom the hospital has "reasonable certainty of receipt."

MGMA Response

ADT alert notifications signal practices to important changes in patients' health status and care management. Proper care coordination requires providers know where patients receive care and then work together to coordinate care. Due to the fact that Medicare programs permit beneficiaries the freedom to visit any provider they choose care delivery teams are often unaware of the other providers beneficiaries visit. Yet physicians can still be held financially accountable for these patients without being aware of encounters such as hospitalizations and emergency department visits. Having that information will permit practices to follow-up on discharge instructions, better coordinate care, and ensure more effective transition sof care.

We urge CMS to adopt the below changes before finalizing this requirement.

- Entities to Receive ADT Alert Notifications

  CMS proposes that notifications be sent "to licensed and qualified practitioners, other patient care team members and post-acute care services providers and suppliers…that receive the notification for treatment, care coordination, or quality improvement purposes." However, it is unclear whether an Accountable Care Organization (ACO) or other entity developed in support of an alternative payment model would fall under that definition. We

recommend CMS that an ACO or other appropriate entity representing groups of physicians and work directly on their behalf, are eligible to receive ADT alert notifications.

- "Reasonable Certainty of Receipt"

  CMS has proposed that when an ADT alert is sent, hospitals must have a "reasonable certainty" the patient's community provider can receive a notification. This "reasonable certainty" standard is not sufficiently specific enough and would inevitably prove difficult for a hospital to determine "certainty." The administrative effort required to ascertain this information could impose a clear burden on the hospital and there would be significant conditions of participation (CoP) liability associated with this requirement.

  As a result of these challenges, MGMA recommends the agency replace the currently proposed "reasonable certainty" standard. Instead, we urge CMS to require that the hospital make a "reasonable effort" to determine if the patient's community provider can receive an ADT alert and transmit that ADT alert to them directly, through an intermediary such as a health information exchange entity, or via other appropriate means.

  Further, CoP requirements in this area should be limited to requiring that the hospital demonstrates having the ability to produce an ADT alert and has made a reasonable effort to identity the patient's community provider (if the patient has one) and made a reasonable effort to transmit the ADT alert to that provider. Hospitals should receive credit if they are able to create the ADT alert but are unable to send the ADT to the community provider through no fault of their own. The use of an intermediary to transmit the ADT, if appropriately documented, should meet the CoP if the intermediary facilitates exchange of notifications in a way that meets the requirements.

- ED Alerts

  In terms of additional event notifications, such as alerts when a patient has visited an ED, this type of ADT alert expansion could provide for a broader set of event notifications. The technology may be in place for ADT alert notification to be applied to ED visits and CMS should encourage hospitals to include ED visits in their ADT alert notifications and explore requiring ED visits in future phases.

- Application

  We agree with the CMS proposal to limit this requirement to only those hospitals which currently possess EHR systems with the technical capacity to generate information for electronic patient event notifications. This approach recognizes that not all Medicare- and Medicaid-participating hospitals have been eligible for past quality reporting programs promoting adoption of EHR systems and thus may not have implemented ADT alert notifications.

- ADT Version

  CMS proposes that hospital system utilize the ADT Messaging standard Health Level Seven Messaging Standard Version 2.5.1 (HL7 2.5.1), an Application Protocol for Electronic Data Exchange in Healthcare Environments, released February 21, 2007. This is a widely-used version of the standard. We understand that version 3.0 is now available, but, unlike version 2.5.1, version 3 is not backwards compatible. We recommend CMS

explore moving to version 3.0 or later versions of this HL7 standard with their additional message types, segments and codes in future phases.

- Flexibility

  In the proposed rule, CMS states they do not wish to restrict hospitals from pursuing more advanced content as part of patient notifications, nor to create redundant requirements where hospitals already have a suitable notification system in place. Accordingly, while CMS requires that hospitals subject to this proposal possess a system utilizing this standard, hospitals may utilize other standards or features to support their notification systems. We support this approach as we believe this added flexibility will permit hospitals to more easily generate the ADT alert notifications. Hospitals should be given appropriate options for sharing ADT messages, and CMS's requirements for data shared with notifications should be considered a floor, not a ceiling.

  Some practices today connect directly with hospitals to receive ADT feeds (often via Direct email or via facsimile), while others leverage their local HIE. It is important to note that while some HIEs are effectively used in certain areas of the nation, many regions lack a well-functioning HIE. Are concerned that the lack of clarity of the proposed new CoP might leave hospitals (and their practice partners) unfamiliar with how they'll comply with the new requirement. Therefore, we urge the agency to issue clarification on the options hospitals will have for meeting the ADT alert requirement. This could be done either through the final rule or in subsequent sub-regulatory guidance. We recommend that hospitals be provided multiple options to comply with the proposed requirements so they may select the optimum approach for working with their community providers.

- Implementation Timeline

  It is clear that ADT alerts will be a valuable tool to allow practices to appropriately manage population health, especially as CMS moves to place physicians at higher levels of financial risk. The proposed rule is unclear when the proposed new CoP would take effect. We recommend that CMS should work with the provider community to implement this new requirement within a reasonable timeline.

- CoP as an Enforcement Tool

  Currently, hospitals are required to produce and transmit ADT alerts as part of the CMS Promoting Interoperability program. We believe this is a more appropriate enforcement lever than CoP as it relates directly to the use of EHRs and the penalty is significantly less than that associated with CoP. Should it be determined by CMS that a hospital has failed to meet the ADT alert requirement, and the institution is excluded from the Medicare program, there would be dire consequences to both the hospital and patients in the community. The hospital would lose potentially a major source of its revenue, an issue which could impact its financial viability. This loss of revenue could impact its ability to offer a full range of medical services and the loss of revenue could even force the hospital to close. This would impact patients in the community and could be devastating should that hospital be the sole or primary patient care facility in the community.

  There are also privacy issues with ADT alert notifications being a CoP. Hospitals, concerned about losing their status as a Medicare provider, might be inclined to transmit ADT alerts prior to fully determining the privacy impact of the transmission. This could lead

to inappropriate disclosures of protected health information. With these issues in mind, rather than leverage CoP, we encourage CMS to use the Promoting Interoperability program as the enforcement lever for the ADT alert requirement.

CMS Request for Information: Patient Matching RFI (Page 7657)

We are soliciting comment on potential strategies to address patient matching.

MGMA Response

MGMA Response

One of the most critical challenges for the healthcare industry is accurately identifying the patient and tying that identification to the appropriate medical record held by an authorized healthcare entity. Even though it was identified as a critical issue in HIPAA and that legislation called for a national patient identifier, the industry does not yet have a standardized, unique patient identifier. We contend that successful interoperability, the exchange of electronic healthcare information, will be extremely difficult to achieve across the nation's healthcare ecosystem in the absence of a cost-effective and accurate method of matching patients to their records.

Patient identification is an acute problem as the nation continues to invest in EHR technology with the patient's electronic "address" often differing across EHR systems. There are significant benefits to adoption of flexible commercial market solutions that consistently demonstrate high degrees of accuracy now and in the future. Identifying the patient correctly is essential for healthcare providers, insurance providers, and others exchanging data for both clinical and administrative purposes. Most importantly, patient care is improved, and patient safety is enhanced when health information is accurately transmitted between healthcare entities, especially in emergency situations.

While numerous patient-matching and identity management initiatives have been undertaken, there currently is no common patient matching strategy that has been adopted by the healthcare industry. Governmental and commercial market collaboration can foster the adoption of such technology solutions and allow them to improve and adapt as technology advances and new techniques are identified. As well, if these solutions are to be effective, they must be easily-implementable and broadly adopted by the industry.

Through the implementation of these recommendations, patient identification accuracy can be greatly increased as new technologies open up access for consumers to increase their literacy regarding health information technology as a means of managing their own health information. It is expected that by strengthening patient identification processes, improvements can be made in linking patients to correct medical records and in information flow at lower costs with reduced medical errors and medical test redundancy. Additionally, it is expected that these efforts would directly correlate to a reduction in fraud and abuse.

Ineffective patient matching can have patient safety and cost ramifications. Patients may receive inappropriate care and face the possibility of medical errors if information used for treatment is missing or inaccurate; one in five hospital chief information officers surveyed said that patient harm occurred within the last year due to a mismatch.

To accurately match records held at different health care facilities, organizations typically compare patients' names, dates of birth, and other demographic data to determine if records refer to the same individual. Health care facilities use algorithms to conduct these matches, and also employ staff to manually review records. This process often fails to accurately link records because of typos

entered into the system; similarities in names, birth dates or addresses among different patients; changing information, such as when individuals move or get married; and many other reasons.

While some private sector technologies—such as referential matching, wherein third-party data are used to support matches—show promise, market forces have been unable to solve the patient matching problem for decades. In fact, patient matching requires collaboration between unaffiliated organizations, even competitors, that lack incentive to agree to a set of standards or develop systems that seamlessly exchange information.

ONC's recent regulations already propose embedding address in the USCDI, but the agency could further improve match rates by requiring use of the USPS standard. To further promote the use of this standard, ONC should also coordinate with USPS to ensure that health care organizations can use the postal service's online, API-based tool—or another easily accessible mechanism—to convert addresses to the USPS standard. There may also be scenarios—such as for military personnel stationed abroad—where the use of the USPS standard is not feasible. ONC could restrict use of the USPS standard to domestic, non-military addresses if challenges arise in the broader use of the standard.

Specific responses to ONC and CMS questions in the patient matching RFI

CMS seeks input on various approaches to address patient matching, minimum data requirements, and measures to assess performance of different solutions.

- *ONC requests input on the potential effect that data collection standards may have on the quality of health data that is captured and stored. ONC also requests input on solutions that may increase the likelihood of accurate data capture, including the implementation of technology that supports the verification and authentication of certain demographic data*. As mentioned above, use of the USPS standard for address would improve match rates and does not require the capture of information in this format given the availability of online tools to conduct the conversion.

- *ONC solicits information on additional attributes that could aid patient matching, and new data that could be added to the USCDI or further constrained within it to support patient matching*. ONC should examine additional data routinely collected in EHRs to also use for matching—such as email address, health insurance ID, mother's maiden name, and others.

- *ONC requests input on the potential effect that data collection standards may have on the quality of health data that is captured and stored and possible impact on accurate patient matching. ONC also requests input on solutions that may increase the likelihood of accurate data capture, including the implementation of technology that supports the verification and authentication of certain demographic data.*

  Better standards for address (according to the U.S. Postal Service standard) would improve match rates. Standardizing according to USPS does not require the capture of the data in this standard, but rather its transformation into this standard once captured (e.g. via an API). Software that automatically converts addresses to the USPS standard is common in commercial internet transactions and could be leveraged in health care. ONC should work with USPS to make its address verification APIs widely available for health care.

- *ONC requests input on additional attributes that could aid patient matching, minimum set of elements for collection and exchange, and data that could be added to the USCDI. ONC*

also requests information on new data that could be added to the USCDI or further constrained within it to support patient matching. In addition to specifying use of the USPS standard for address, ONC should examine additional data routinely collected in EHRs to use for matching—like email address, health insurance ID, mother's maiden name, and others. ONC should add those data elements that are already collected to the USCDI.

- *ONC also seeks comments on potential solutions that involve patients in the capture, update and maintenance of their own demographic and health data.* Patients could validate their demographic information by verifying their mobile phone number and other data. In addition, EHRs could support smartphone applications that use standard APIs to allow patients to update their demographic data. ONC and industry partners could pilot these approaches.

- *ONC requests input on other innovative approaches to address patient matching*. The agency should explore promising new approaches to patient matching that have not yet been widely used in healthcare including biometrics approaches such as fingerprint or facial recognition scans.

- *ONC seeks input on performance measures and indicators that can be used to evaluate patient matching algorithms*. Benchmarking different approaches would help shed a spotlight on matching deficiencies and the wide variation in quality across different algorithms. Technology developers could then use that information to improve their algorithms, and health care providers could adopt the most promising approaches. ONC should work with CMS to determine how to benchmark different matching approaches; this likely requires the identification of a large, real-world data set to test different algorithms.

  The use of real-world data, rather than synthetic data, is essential given that some innovative approaches—such as referential matching—use third-party databases to support their algorithms. ONC or CMS may be able to indentify grantmaking authorities or other policies to obtain such a data set for benchmarking. This benchmarking could assess duplicate creation rates, the number of records correctly matched, and the frequency with which records are incorrectly merged.

- *CMS requests information on whether to require program participants use a patient matching algorithm or solution with a "proven" success validated by HHS or a third party*. CMS should examine how to benchmark different approaches to patient matching to provide better information on the variation across matching algorithms and to highlight current limitations. However, benchmarking—on its own—will not improve match rates; CMS should work with ONC to optimize the use of demographic data (including adoption of the USPS standard for address and the use of additional data elements).

- *CMS requests information on whether to expand recent Medicare ID card efforts by requiring a CMS-wide identifier for all beneficiaries and enrollees in healthcare programs under its administration and authority*. Implementing an agency-wide identifier may help CMS better serve beneficiaries and improve matching. However, this approach is still insufficient to address matching on a nationwide scale.

  We note that a unique identifier would still face limitations in matching patients to information prior to enrollment in federal health insurance programs, and they are still susceptible to errors (e.g. typos that exist today with the use Social Security Numbers). Given those limitations, even if CMS pursues broader use of a CMS-wide identifier, the agency should still push forward with optimizing the use of demographic data (including adoption of the

U.S. Postal Service standard for address and the use of additional data elements).

- *Finally, CMS requests information on whether it should advance more standardized data elements across all appropriate programs for matching purposes, perhaps leveraging the USCDI proposed by ONC*. CMS should work with ONC to advance both the use of the USPS standard for address and the addition of other elements—like email address—to the USCDI.

Patient matching recommendations:

- Initiate public-private sector collaboration.
    - Identify best practices related to private-sector patient matching solutions, and make recommendations to the HHS Secretary. This effort should include exploring expanding the USCDI to include additional criteria such as email address that could be leveraged for patient matching purposes. Recommendations should ensure sufficient flexibility to account for potential new technologies and solutions.
    - Develop pilots of one or more of these identified best practices.
    - Explore having HHS set a floor for error matching rates. Once they have met the "floor," permit entities the flexibility to determine what solution works best for them.
    - Explore having ONC provide certification and/or oversite over patient matching solutions.
    - Explore enforcement (i.e. data blocking) safe harbors for entities making good faith efforts at patient matching and meeting appropriate patient matching guidelines.
    - Identify potential patient matching solution dissemination strategies and make recommendations to the HHS Secretary.
- Support the standardization of some demographic data, particularly applying the USPS standard to an individual's address.
    - ONC has taken the first step to include address among the demographic data elements proposed in the USCDI. ONC should build on the addition of address to the USCDI by specifying the use of the USPS standard for address. ONC should incorporate this change in the final rule.
    - ONC should explore publicly available options for APIs that can transform address into the USPS standard. Commercial options exist for this transformation, and the USPS has an API that enables this transformation. ONC should work with the USPS to ensure that this API is available for health record matching.
- Adopt additional data elements for patient matching.
    - ONC should advance the use of regularly collected demographic data elements for patient matching. ONC currently requires EHRs to make some demographic data—such as name, birth date, and sex—available, and proposes to add address and phone number to the USCDI. However, health records contain other demographic data routinely collected that aren't typically used or made available to match records. For example, email addresses are typically already being captured by practices. The documentation of email is likely higher today, given the adoption of patient-facing tools, like portals, that often require emails to register.
    - ONC could improve match rates by identifying and including in the USCDI readily available data elements—such as email address, mother's maiden name, or insurance policy identification number—that health information technologies should use for matching.

- Finally, in concert with the healthcare industry, CMS and ONC should initiate an awareness and education campaign aimed at critical healthcare stakeholders, with emphasis on patients, practices, and HIEs.

There are a number of issues that should be considered as a national patient matching strategy is developed. These include the potential employment of mobile technology and the use of alternative matching criteria such as email addresses, health insurance ID, mother's maiden name, and others. Further, CMS and ONC should examine how to benchmark different approaches to patient matching to provide better information on the variation across matching algorithms and to highlight current limitations.

Conclusion

In conclusion, MGMA supports the objective of deploying HIT in physician practices to improve the sharing of clinical data between physician practices and other care settings and decrease administrative burdens. However, considerable work must be accomplished to overcome the numerous technical, legal, and logistical barriers to the widespread and effective use of health IT. Through implementation of appropriate policies, processes, and incentives, as well as outreach to physician practices and other key stakeholders, we believe that the nation's health IT infrastructure can achieve the goals and vision laid out in the Cures Act.

With the publication of this proposed rule, CMS has taken on the formidable task of reshaping public policy in an effort to create a healthcare environment that leads to improved patient care and more efficient delivery of care. We look forward to continuing to work with CMS and other federal agencies to facilitate physician practice transition to effective and efficient health IT and ensure that the promise of improving the nation's healthcare system through technology becomes a reality. Should you have any questions regarding these comments, please contact Robert Tennant, Director, Health Information Technology Policy, at 202.293.3450 or rtennant@mgma.org.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs