



National Association for the Support of Long Term Care

April 3, 2020

Donald Rucker, MD
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health & Human Services
Mary E. Switzer Building, Office 7009A
330 C Street, SW
Washington, DC 20201

Dear Dr. Rucker:

I am writing on behalf of the National Association for the Support of Long Term Care (NASL), which represents the federal legislative and regulatory interests of ancillary service providers, focusing on the intersection of clinical, diagnostic testing and health information technology (health IT) issues. NASL members are providers of care and rehabilitation therapy services (*i.e.*, physical therapy, occupational therapy and speech language pathology); clinical laboratory and portable x-ray services; as well as developers and vendors of health IT solutions serving the majority of the long term and post-acute care (LTPAC) sector. NASL is proud to be a founding member of the LTPAC Health IT Collaborative, which has been working to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders since 2005.

Overview

We at NASL recognize that the most pressing health care issues at this time center on how we deal with the worldwide pandemic – Coronavirus disease 2019 (COVID-19). While we cannot predict the outcome, we instinctively know that the COVID-19 pandemic will challenge the Nation’s healthcare system – and healthcare systems across the globe – in ways that few have considered possible. What is clear at this point in time is that combatting this pandemic will demand more from our already limited resources. We appreciate the flexibilities afforded under the national Public Health Emergency and the National Emergency, which was declared on March 13, 2020 and which waive certain federal requirements. Even with those accommodations and the many more that have followed thus far, more is needed. Our Nation needs to deliver on the promise of interoperability so that critical clinical information may be made available securely and in a way that supports the essential care delivered by physicians, nurses, pharmacists, therapists, laboratory and portable x-ray technicians and other frontline caregivers without compromising patient privacy and protections that remain central tenets of the healthcare profession.

NASL is eager to share our thoughts on the US Department of Health & Human Services' (HHS') draft [2020 – 2025 Federal Health IT Strategic Plan](#). We appreciate the effort put forth by the HHS Office of the National Coordinator for Health Information Technology (ONC) in coordinating more than 25 federal agencies to update the *Federal Health IT Strategic Plan* as required under the *Health Information Technology for Economic & Clinical Health (HITECH) Act*. The plan reflects the broad range of input and priorities that ONC included in this draft plan.

NASL understands that this plan will be used as a roadmap for federal agencies to prioritize resources and to align and coordinate efforts across agencies. We also recognize that ONC will use the plan to signal priorities to the private sector and for benchmarking and assessing change over time. ONC also is leveraging the work to update the plan as a way of underscoring key objectives such as ensuring individuals' access to their electronic health information, creating new business models through the use of Application Programming Interfaces (APIs), establishing data sharing practices and providing an operational tool for managing federal activity and collaboration.

NASL believes that health information technology (health IT) serves as the crucial underpinning for achieving our shared vision for “a health system that uses information to engage individuals, lower costs, deliver high-quality care, and improve individual and population health.”

The plan centers on four goals: 1) promoting health and wellness; 2) enhancing the delivery and experience of care; 3) building a secure, data-driven ecosystem to accelerate research and innovation; and 4) connecting healthcare and health data through an interoperable health IT infrastructure. We support these overall goals; however, the plan does not provide enough detail with regard to the necessary objectives and strategies for achieving these broad goals.

Overarching Recommendations

NASL agrees with the draft plan's vision for using health information to lower costs, increase care quality and improve individual and population health. We also support the plan's stated mission to improve the health and well-being of individuals and communities using technology and health information that is accessible when and where it matters most.

NASL is confident that our federal partners are working to advance interoperability that can improve care coordination and care quality. Moreover, we appreciate how challenging it is to address each of the myriad components of such an intricate plan. Even so, we are disappointed that some of the strategies that we believe would be most efficacious in achieving these ambitious goals were either overlooked or simply not considered in drafting this plan. From our perspective, the silos that have emerged over time and around the Centers for Medicare & Medicaid Services' (CMS') various prospective payment systems – ranging from inpatient acute care, post-acute care and home health to ambulatory care – undercut our collective interest in advancing interoperability and greater coordination of care. In addition, silos exist with regard to inconsistent policies across Medicare Parts A & B even though the patients served by each are often the same individuals.

NASL Recommendation

NASL recommends that the *Federal Health IT Strategic Plan* be amended to reflect the full spectrum of our nation's healthcare system. Specifically, we request the Secretary of HHS to direct an assessment of the entire healthcare landscape within its jurisdiction to identify ways to harmonize data collection and quality and health IT initiatives that would bring critical efficiencies to our healthcare system.

In particular, HHS should review the disparate programs, quality measures and technical requirements that impact Medicare and Medicaid providers and bring conflicting regulations into alignment so that providers may focus more directly on patient care needs as beneficiaries transition across providers, care settings and the healthcare continuum. For example, the Merit-based Incentive Payment System (MIPS) was designed to encourage improvement in care quality; yet, it draws on quality metrics that are attainable more easily by physicians working in acute and ambulatory care settings than those practicing in post-acute care settings. Physicians who provide quality care should not be disadvantaged by the setting in which they practice. Instead, HHS should review its various quality programs and measures to bring greater alignment that rewards quality care regardless of the setting.

Achieving Interoperability

The section of the draft plan entitled "Achieving Interoperability" cites federal government programs that have achieved success by incentivizing interoperability of health information in the acute and ambulatory sectors. We applaud those efforts and welcome that progress. We disagree, however, with the notion that "regulatory actions from ONC and CMS" are the reason that the private sector increasingly is developing Application Programming Interfaces (APIs) for data sharing. At least, the LTPAC sector has no federal requirement or incentive to adopt health IT or to electronically share information; yet, NASL member companies have been part of Carequality and CommonWell and a variety of initiatives over the years seeking to increase health information exchange – again without benefit of any federal investment or requirement to do so.

Regardless, we believe that the *Draft 2020 – 2025 Federal Health IT Strategic Plan* is too narrowly focused on those sectors of our healthcare system that received federal incentive funds for the adoption and use of health IT. We concede that health IT adoption in post-acute care continues to lag behind that of eligible hospitals and providers; nonetheless, HHS should recognize *all* efforts to participate in the electronic exchange of information and refrain from viewing all providers and all health IT developers through the same lens.

NASL and other key stakeholders have much to contribute to an overall, cohesive effort to speed interoperability. We believe that there should be greater parity across sectors and policy strategies that can advance the business case for interoperability for those that have not received federal incentives to adopt and use health IT.

NASL Recommendation

NASL recommends that federal support be extended to incentivize health IT adoption by all post-acute care providers in order to ensure that those caring for America's seniors and underserved through participation in Medicare and Medicaid will have the resources needed to fully participate in robust health information exchange. True parity across sectors would mean financial support from the federal government for those deemed "ineligible" for incentives under the *HITECH Act*. We recognize that such equality is highly unlikely – even before the COVID-19 pandemic. We welcome support in the form of technical assistance, training and regulatory accommodations regarding timelines and other requirements for implementing health IT.

Reducing Regulatory & Administrative Burden

The section on reducing regulatory and administrative burden postulates that current system designs are burdensome to providers because electronic health records (EHRs) were designed "to support reimbursement and financial processes" rather than improving patient care and outcomes. We think that it is relevant to note that the clients who purchased these EHRs and health IT systems were – and are – interested in tracking reimbursement and financial processes in addition to patient care and outcomes. We agree that "activities such as clinical documentation and prior authorization take time and that health IT should help to minimize provider burden and reporting requirements. While we cannot speak to system design used in acute and ambulatory care settings, health IT developers that serve the LTPAC sector follow the technical specifications issued by the Centers for Medicare & Medicaid Services (CMS). We also respectfully remind HHS that much of the reporting requirements addressed in LTPAC health IT is there to meet federal and state requirements for Medicare and Medicaid providers.

The sea change that is underway will move our healthcare system from fee-for-service to value-based care. This shift is putting added demands on often limited resources that Medicare and Medicaid providers have. In the LTPAC sector, the proliferation of Medicare Advantage plans and Medicaid waivers has contributed to provider burden as providers must track multiple and nuanced payer requirements.

We believe that streamlining how the federal government approaches value-based care has the potential to deliver greater efficiencies and benefit providers by reducing administrative burden. HHS should better manage Medicare Advantage Plans and Medicaid waivers by implementing some measure of standardization for billing, data collection, reporting and other administrative processes that providers must follow for each plan and each State. For example, CMS implemented the new Medicare payment system for skilled nursing facilities (SNFs) last fall, the Patient Driven Payment Model (PDPM). State Medicaid programs utilize aspects of the federal payment system in their own Medicaid payment systems, but few states adopted the new payment system, which meant that health IT vendors had to maintain previous systems to use for Medicaid reimbursement in states

that did not adopt PDPM, while fully implementing PDPM to use for Medicare reimbursement from CMS. The irony is that often the reimbursement submitted by SNFs is for the same patient, who is dually eligible for Medicare and Medicaid. Approximately 70% of those in nursing facilities are dually eligible for Medicare and Medicaid. These beneficiaries often begin a stay under Medicare Part A coverage before transitioning coverage to Medicaid and Medicare Part B. Again, this example points to how each deviation from a standard complicates what types of programs, reporting and systems must be maintained, and certainly runs counter to the Administration's significant efforts to reduce provider burden.

NASL Recommendation

NASL believes that streamlining the myriad reporting and data collection requirements – to include those related to participation with Medicare Advantage organizations – would make a marked difference in provider burden and health information exchange. Instead of allowing each plan to set its own rules and formats for data collection and reporting, CMS should require Medicare Advantage plans to use the same format, which would speed the administrative processes that adds burden for providers. In addition, CMS should provide a master list of State requirements that are contained in State Plan Waivers that have been approved by CMS. For providers that operate across multiple states, and the health IT vendors that support providers nationwide, tracking a single, consolidated source of technical and operational requirements would save time and resources that currently are devoted to tracking down information that we believe could be easily compiled by CMS in the course of its regular waiver process.

Privacy & Security of Health Information

NASL continues to have serious concerns regarding how the privacy and security of health information can be maintained, and hopefully enhanced, as we move toward interoperability. We agree that there is a tremendous need to educate individuals, their caregivers and providers alike on “data practices, their associated risks and opportunities to provide consent to these uses.” Because patients cared for in the LTPAC sector – whether at home or in a facility – may have cognitive issues that make obtaining consent more challenging than it is for health care consumers who are active participants in their own care, we are even more concerned about the lack of detail regarding a strategy for implementing what certainly will be a massive, albeit necessary, educational effort.

To begin, NASL requests clarification regarding the definition of consent in the context cited above. We agree with the need to educate patients and providers alike on privacy and what giving consent to share one's health information truly means. There are significant concerns about patient confidentiality, especially given the complexities of ensuring patient privacy and security protections under the *Health Information Portability & Accountability Act (HIPAA)* are met and the integrity of patients' electronic health information is maintained. We urge the federal government to prioritize achieving provider-to-provider exchange of health information before expanding health information exchange efforts beyond *HIPAA*-compliant entities. Certainly, in the absence of patient and

caregiver education around data practices, risk and consent, the government should not open the proverbial barn door to allow non-*HIPAA* compliant actors access to patients' health records. Therefore, NASL recommends that HHS focus on achieving more seamless provider-to-provider exchange and establishing a national infrastructure for health information exchange before introducing non-*HIPAA* compliant actors and products.

Goals, Objectives & Strategies

NASL reviewed the *Draft 2020 – 2025 Federal Health IT Strategic Plan* and has a few comments regarding specific goals, objectives and strategies.

Goal 1: Promote Health & Wellness

Objective 1a: Improve individual access to health information

NASL appreciates that HHS included a strategy to “Provide resources on how to access and use health information so that patients and caregivers understand how to use their data safely, securely and effectively.” We agree with the importance of this strategy. We request clarification regarding the specific data elements that comprise the “data” HHS is referencing in this strategy. We also ask that HHS specify the kind of resources that would be provided and in what amount.

Objective 1b: Advance healthy & safe practices through health IT

NASL is keenly interested in the strategies around advancing healthy and safe practices through health IT, to include advancing the use of evidence-based digital therapeutics as treatment options for patients to prevent, manage and treat conditions through smartphones, tablets and other personal devices. What is missing from the strategies outlined in the *Draft 2020 – 2025 Federal Health IT Strategic Plan* is how these strategies align with current Medicare policy, such as the restrictions on the use of telehealth.

Clearly, we are learning even more about the importance of predicting epidemics and monitoring public health as we actively address the Coronavirus pandemic. We anticipate that this global phenomenon will be pivotal in changing how providers across the entire healthcare continuum view health information technology and the ability to exchange health information.

NASL Recommendation

NASL supports the removal of geographic and other restrictions on the use of telehealth in the LTPAC sector and recommends that HHS reconsider its policies as it relates to the health IT strategies in this draft plan. Again, we believe that HHS to reassess its policies, and telehealth policies in particular, in the wake of our experiences with flexibilities enacted in response to the COVID-19 pandemic.

Objective 1c: Integrate health & human services information

NASL agrees that there is limited integration of data among the various federal, state, regional and

local agencies for coordinating care, whereas LTPAC providers are well-versed in treating the whole patient on a longitudinal basis and not just an episode of care. HHS should look to the long term and post-acute care sector for expertise on care coordination.

We question the wording of the strategy which currently reads, “Strengthen communities’ health IT infrastructure by facilitating bi-directional, secure exchange of data across healthcare and human services settings to improve care and effectively administer social programs.” Rather, we believe that having a health IT infrastructure that can facilitate bi-directional, secure exchange of data would strengthen communities’ abilities to improve care and effectively administer social programs.

While we appreciate that capturing and integrating social determinants of health data into EHRs would inform caregiving, address certain health disparities and improve the overall patient care, this strategy seems more like an aspirational goal given the ongoing challenges around achieving provider-to-provider exchange across the healthcare continuum.

NASL Recommendation

We recommend beginning with a simpler, initial approach while work is done on social determinants of health. NASL believes that there are important gains to be realized by aligning claims data with clinical data. For example, CMS’ reimbursement for long term and post-acute care relies largely on claims data. We recommend that reimbursement also be informed by what is captured by the four post-acute care settings’ patient assessment instruments – *i.e.*, the Home Health Outcome & Assessment Information Set (OASIS), Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), Long Term Care Hospital (LTCH) CARE Data Set (LCDS) and the Skilled Nursing Facility (SNF) Minimum Data Set 3.0 (MDS 3.0). By better aligning clinical data with claims, providers will have a better picture of the patient under their care.

Goal 2: Enhance the Delivery and Experience of Care

Objective 2b: Foster competition, transparency, and affordability in healthcare

NASL appreciates that the plan encourages “pro-competitive business practices that allow individuals to easily use and choose from multiple validated health apps and other health IT tools without special effort.” It is unclear how such health apps would be validated. Will health apps need to meet ONC Certification Program criteria? If so, which criteria would need to be met and how would ONC validate these apps?

Goal 4: Connect Healthcare & Health Data through an Interoperable Health IT Infrastructure

Objective 4a: Advance the development & use of health IT capabilities

We agree that there is a growing need for healthcare providers and others to keep pace with the continually evolving digital health landscape. We are especially interested in the strategy to “reduce financial and regulatory barriers that are perceived to prevent new health IT developers from

entering and competing in the health IT market place.” It is curious that HHS would focus on new health IT developers when there has been no such strategy to ensure consideration of the health IT developers that have partnered with various federal agencies over the years and implemented myriad federal technical specifications. NASL requests clarification as to what supports are available for existing health IT developers to include NASL members that have worked to advance federal health IT goals and strategies without benefit of incentive strategies or other accommodations.

NASL Recommendation

Rather than promoting a digital economy or focusing on removing barriers for new health IT developers that may or may not understand the complexities around federal health care policy, NASL recommends that HHS focus on more fully defining the value and usefulness of interoperable information and the exchange of that information to improve care quality.

Closing

NASL believes our recommendations bring an important perspective that does not appear in the current *Draft 2020 – 2025 Federal Health IT Strategic Plan*. Because the full impact of the COVID-19 pandemic is yet to be realized, we have one additional and overarching recommendation.

NASL recommends that HHS *not* finalize the *Draft 2020 – 2025 Federal Health IT Strategic Plan* until such time as there can be some evaluation of the impact of temporary and other provisions enacted in response to and during the COVID-19 pandemic.

We believe that the sea change in the adoption and use of health IT ushered in by the *HITECH Act's* Meaningful Use, and now the Promoting Interoperability programs, could pale in comparison to the changes brought about by the upheaval around the COVID-19 pandemic. We are hopeful that the necessary flexibilities granted to Medicare and Medicaid providers and the innovations their health IT partners deliver during these unprecedented times ultimately will help to fulfill the promise of health IT that all of us have been striving to advance.

NASL welcomes the opportunity to work with our federal partners and stakeholders across the healthcare continuum to improve care through the use of interoperable health information and technology.

Sincerely,



Cynthia Morton
Executive Vice President