

CMS NPRM (Feb 2019): Patient Matching RFI (p. 7656-7)

Public health has significant experience over a long period of time in patient matching strategies for records collected from diverse clinical locations. The following observations and suggestions are offered based on this experience:

| RFI Question | Response |
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| <p>1. Should CMS require Medicare FFS, MA Plans, Medicaid FFS, Medicaid managed care plans (MCOs, PIHPs, and PAHPs), CHIP FFS, CHIP managed care entities, and QHP issuers in FFEs (not including SADP issuers), use a patient matching algorithm with a proven success rate of a certain percentage where the algorithm and real world processes associated with the algorithm used are validated by HHS or a 3rd party?</p> | <p>This has always been a difficult topic and we do not see any easy answers ahead. In 2017 ONC sponsored the Patient Matching Algorithm Challenge (PMAC) whose was to allow vendors to compete for the highest performance metrics for their matching algorithms by testing their software against a large set of test data provided by ONC. Cash prizes were awarded in a number of categories, and the winning vendors were featured in the discussion on the webinar. One of the main purposes of the challenge was to promote the use of standard metrics to evaluate algorithm products. We were a little concerned that the winners by their own admission “analyzed patterns in the data.” This seems to call into question the applicability of their results to the “real world” where you don’t get to see the data set; you have to adjudicate them as they come in. That means that these particular test runs were “tuned” for the data set and the measurable results might not hold up for other data sets.</p> <p>Over the years, several public health initiatives have attempted to provide comparative measures of matching algorithm performance or quality and have had less than successful results.</p> |
| <p>2. Should CMS require Medicare FFS, the MA Plans, Medicaid FFS, Medicaid managed care plans, CHIP FFS, CHIP managed care entities, and QHP issuers in FFEs to use a particular patient matching software solution with a proven success rate of a</p> | <p>See response to question 1 above.</p> |

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| <p>certain percentage validated by HHS or a 3rd party?</p> | |
| <p>3. Should CMS expand the recent Medicare ID card efforts by requiring a CMS-wide identifier which is used for all beneficiaries and enrollees in health care programs under CMS administration and authority, specifically by requiring any or all of the following:</p> <ul style="list-style-type: none"> • That MA organizations, Part D prescription drug plan sponsors, entities offering cost plans under section 1876 of the Act, and other Medicare health plans use the Medicare ID in their plan administration. • That State Medicaid and CHIP agencies in their FFS or managed care programs use the Medicare ID for dual eligible individuals when feasible. • That QHP issuers in FFEs use the Medicare ID for their enrollees in the administration of their plans. | <p>We have no response to this question.</p> |
| <p>4. Should CMS advance more standardized data elements across all appropriate programs for matching purposes, perhaps leveraging the USCDI proposed by ONC for HHS adoption at 45 CFR 170.213.</p> | <p>As we described in an article published in 2017, ONC convened a Patient Matching Community of Practice in 2014-15. We wrote, “Its major focus was developing a five-level data quality maturity model to try to characterize an organization’s sophistication in using different common data elements to perform patient matching functions, as well as articulating value propositions for improved matching for different stakeholder types. The project released two documents, Developing and Testing a Data Management Model and Maturity Scale Tailored to Improving Patient Matching Accuracy and Guidelines for Pilot Testing of Data Management MaturitySM Model for Individual Data Matching describing its work. The Data Quality Maturity Scale, included as Appendix B, highlights how systems across the healthcare community, at</p> |

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| | <p>least as reflected in the core data elements, are at the high levels of maturity. In practice, however, the data elements needed for levels 4 and 5 are precisely the ones that are least consistently captured.” We encourage ONC to draw on these documents and resources whose development ONC funded.</p> <p>In addition, in January 2019 AIRA published its IIS Functional Guide, Vol. 2: CDC Endorsed Data Elements. This exhaustive document includes (in Appendix C) a list of data elements endorsed to fulfill the IIS functional standard of identifying, preventing and resolving duplicated and fragmented patient records using an automated process. This list is also worth consulting.</p> <p>With respect to USCDI, we note that ONC is requesting an exemption for USCDI from The National Technology Transfer and Advancement Act (NTTAA) requirements that standards adopted by the Federal government must be developed or adopted by voluntary consensus standards bodies. We do not support this exemption. The development of these artifacts has typically <i>not</i> involved public health representation; at minimum, someone should represent public health on the USCDI Task Force.</p> <p>Research in New York City by the Citywide Immunization Registry (CIR) has demonstrated that though matching is a complex activity, and it is difficult to tease apart factors affecting successful matching, the search success rate for the CIR was higher when more search fields were sent, especially the internal ID assigned to each patient in the CIR and available to EHRs that query the system should they choose to store it. Studies such as</p> |

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| | <p>this one should be replicated to help determine the most effective fields for searching and matching.</p> <p>External validation of key data elements used for matching can also be a big help. For example, in 2017 the American Immunization Registry Association (AIRA) arranged access to SmartyStreets, a cloud-based address cleansing service, for all Immunization Information Systems (IIS) which chose to access it. By leveraging available CDC funding, for a modest amount this service is able to cover the <i>entire</i> IIS community and significantly increase the level of quality in address data which is often key for proper patient matching. AIRA maintains the license, provides documentation and coordination, and sponsors a monthly user group of interested IIS projects.</p> |
| <p>5. Should CMS complement CMS data and plan data in Medicaid managed care plans (MCOs, PIHPs, and PAHPs), CHIP managed care entities, MA Plans, and QHP issuers in an FFE (not including SADP issuers) with one or more verifying data sources for identity proofing? What potential data source should be considered? What are possible restrictions or limitations to accessing such information?</p> | <p>We have no response to this question.</p> |
| <p>6. Should CMS support connecting EHRs to other complementary verifying data sources for identity proofing? What potential data source should be considered? What are possible restrictions or limitations to accessing such information?</p> | <p>We have no response to this question.</p> |
| <p>7. To what extent should patient-generated data complement the patient-matching efforts?</p> | <p>We have no response to this question.</p> |