NYeC
NEW YORK eHEALTH COLLABORATIVE

Valerie Grey
Executive Director

July 10, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building 200 Independence Avenue, S.W.,
Room 445-G
Washington, DC 20201

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals.

Dear Ms. Verma:

The New York eHealth Collaborative (NYeC) is pleased to provide these comments in response to the proposed Hospital Inpatient Prospective Payment System (IPPS) Fiscal Year 2021 rule. NYeC is a 501(c)(3) and New York's State Designated Entity (SDE) charged with the governance, coordination, and administration of the Statewide Health Information Network for New York (SHIN-NY). In this capacity, NYeC works in a public/private partnership with the New York State Department of Health (NYS DOH) on the development of policies and procedures that govern health information exchange through the SHIN-NY. The SHIN-NY is a "network of networks" consisting of Qualified Entities (QEs) also known as Regional Health Information Organizations (RHIOs) and a statewide connector that facilitates secure sharing of clinical data from participating providers' electronic health records (EHRs). The SHIN-NY connects all hospitals in the state, is used by over 100,000 healthcare professionals, and serves millions of people who live in or receive care in New York. NYeC also served as a Regional Extension Center and leads a variety of programs designed to help providers select, implement, and leverage EHRs and HIE to transform healthcare.

NYeC appreciates the opportunity to provide comments and input on the IPPS FY 2021 proposed rule, highlights of our comment letter include:

- We support CMS proposals that would progressively phase-in the reporting of eCQM data reporting and extend as optional the PDMP and EHR integration.
- CMS could strengthen quality measurement by further promoting HIE usage and learning from New York's experience.
- Investment, support, and incentives for non-Meaningful Use (MU), left-behind sectors including LTPAC, is critically needed to truly transform healthcare and improve quality of care for Medicare beneficiaries.
- CMS and federal agencies must do more to ensure adherence with standards on race and ethnicity to support work to address health disparities in both COVID-19 and more broadly.
- While we support patient access to their health records, we remain concerned about how clinical data will be used in a non-HIPAA environment and encourage more work in this area.

Promoting Interoperability Program

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NYeC is generally supportive of the proposed changes to the Medicare and Medicaid Promoting Interoperability Programs. We appreciate CMS' focus on reducing provider burden and accelerating interoperability. Detailed comments are below.

Clinical Quality Measurement

We applaud CMS for supporting technology that reduces burden and allows clinicians to focus on providing high quality healthcare for their patients. We also support the policy goals of leveraging EHR-based quality measure reporting to incentivize data accuracy, promote interoperability, increase transparency, and reduce long-term provider burden by providing public access to the reported eCQM data. However, we feel that that CMS could accelerate these goals by explicitly incentivizing reporting via HIEs. An HIE's role as a data aggregator across sources has the promise of additional robustness of measurement with more comprehensive data, efficiency, and standardization.

- **Claims Integration:** New York has been working to integrate claims data into the SHIN-NY and we are exploring opportunities to support health plans vis-a-vis the CMS Interoperability Rule. This could be a further opportunity for alignment and ultimately enhance reporting and accuracy of quality measures for provider performance and patient safety.

- **NY Quality Measurement Pilots:** The SHIN-NY has developed quality measurement capabilities with pilots as part of our State Innovation Model with Centers for Medicare & Medicaid Innovation. These pilots led to collaboration with the National Committee for Quality Assurance (NCQA) on two major initiatives. One collaboration is a Data Aggregator Program, which could enable HIEs to provide Healthcare Effectiveness Data and Information Set Supplemental Data for health plans, including Medicare Advantage and NYS Medicaid Managed Care Plans. The second is a comprehensive analysis of emerging quality measure specifications to assess how HIE data informs specifications, which includes significant manual processes like medical record review, chart abstractions, etc. We encourage CMS to undertake similar innovative initiatives to refine eCQMS with the dual goals of improved accuracy and burden reduction.

- **Patient Level Quality Report:** We support the expansion to any future hybrid measure adopted into the Hospital Inpatient Quality Reporting (IQR) Program to enable the creation of an individual patient-level quality report that contains data for one patient and with one or more quality measures. This is a central functionality of HIEs: to link across data sources, patients, and subsequent quality measures. We would also note that this functionality, with the appropriate incentives for standards, can support other important use cases such as public health reporting.

- **Race and Ethnicity Data:** During our COVID-19 public health support, we found that the need for reporting of and adherence to standards for capturing race and ethnicity has been critical. HIEs can provide timely information and reduce provider burden. CMS could further enable this by explicitly referencing HIEs and by promoting adherence to standards in the reporting of quality measures. The IQR Program represents a strategic opportunity to promote patient level reporting, including emphasis on specific data elements like race and ethnicity, which help the industry better understand health disparities and inform social determinants of health.

- **Implementation Timeline:** Finally, we support the proposal to progressively increase the number of quarters for which hospitals are required to report eCQM data and believe this will produce more comprehensive and reliable quality measure data for patients and providers. We

also agree that taking an incremental approach over a three-year period would give hospitals and their vendors time to plan in advance and build upon and utilize investments already made in their infrastructure. This is another area where an increased focus on leveraging HIEs in the eCQM development and reporting process could enable the long-term infrastructure necessary to streamline the iterative refinement and creation of eCQMs.

Prescription Drug Monitoring Program

New York has a robust and operational PDMP (I-STOP) that is presently queried by providers at a rate of over 18 million queries annually. However, these queries are not typically performed via CEHRT but rather through a process that exists outside of the clinician's EHR via a state-secured portal. While the ultimate goal is to support widespread EHR integration with the PDMP, this level of integration is not yet in place. Considering the current state of EHR to PDMP integration, it is expected that comprehensive statewide implementation of PDMP query via CEHRT will take significant time to implement across all providers and EHRs in the state. We support CMS's proposal to extend the measure as optional in CY 2021 to allow time for further progress around efforts to integrate PDMPs into EHRs, thus minimizing the burden on eligible hospitals and CAHs.

Interoperability

NYeC applauds CMS' leadership in promoting interoperability and for seeking stakeholder feedback on additional efforts CMS can undertake to further accelerate interoperability. CMS should continue to push for open application programing interfaces (APIs) and for providing patients electronic access to their health information. Both efforts will accelerate interoperability overall. Below are some additional points for CMS to consider in future improvements for interoperability.

- **Adoption of EHRs Beyond Meaningful Use (MU) Providers:** We believe supporting widespread adoption of EHRs and participating in the electronic exchange of health information such as the SHIN-NY is essential to improved patient outcomes that are implicated in numerous hospital clinical quality measures. The widespread adoption of EHRs and participation in the SHIN-NY has been an essential component in supporting New York State's broader payment reform initiatives.

  New York State hospitals, home health care agencies, long-term home health care programs, and hospices that use CEHRT are required to participate in and contribute data to the SHIN-NY. Since 2014, New York State, with support from CMS, has provided financial support to providers who connect to the SHIN-NY and contribute clinical data through the Data Exchange Incentive Program (DEIP). DEIP is available to physicians participating in the former MU program, skilled nursing facilities, home care agencies, hospices, and behavioral health providers.

  Success in payment reform will require bringing a broader array of healthcare providers and non-traditional entities into the electronic data infrastructure fold. However, many of these left behind entities lack certified products, as health IT developers and providers have limited incentives to develop and adopt them. It is essential to address this gap moving forward. We strongly encourage CMS to consider policy levers that could support these non-MU incentivized providers in adopting certified EHRs and participating in the electronic exchange of health information. New York has been focused on the role of social determinants of health and we see many opportunities for alignment and collaboration with HIEs to improve health outcomes in the future.

- **Privacy and Security of Third-Party Applications:** We appreciate that patient access to electronic health information, facilitated through third-party applications, is a priority of CMS. NYeC supports these efforts to empower patients and agrees that individuals should be able to easily access, exchange, and use their health information across platforms. However, in the era of open application programming interfaces (APIs) there is valid concern among many healthcare stakeholders that sharing healthcare data through third-party applications not regulated by HIPAA could result in negative, unintended consequences for consumers who may be unaware of how their data is being used. We suggest that CMS work with other agencies across HHS to provide guardrails, as well as advance consumer education, on privacy and security policies for non-HIPAA entities.

- **Public Health:** The COVID-19 pandemic has illustrated the importance of a strong public health exchange infrastructure for responding to public health emergencies. New York has leveraged hospital information from the SHIN-NY to provide support to public health for surveillance and research activities. The QEs provide public health reporting to state and local public health departments and deliver key clinical data for COVID-19 positive, or presumed positive, patients. Given the COVID-19 pandemic, it is increasingly important that data collected and reported to public health agencies is complete and include key demographic data that enables real-time identification of surges in infection, or is useful for research or predictions. However, as discussed above, our experience responding to COVID-19 has revealed significant gaps in the capturing and reporting of race and ethnicity data, which leads to further health disparities and gaps in care among minority and other vulnerable populations. While the CCDS and USCDI provide a baseline set of demographic data that must be available for exchange, often the appropriate data is either not collected or is collected in a non-standardized format, making it challenging to use for policy and decision making.

  Recently, HHS announced new guidance that specifies what additional data must be reported to HHS by laboratories along with COVID-19 test results.[1] CMS could align with this guidance by providing hospitals with incentives through the PI Program to collect and exchange such additional data in standardized formats. Comprehensive, standardized reporting of public health information will allow for more effective disease surveillance and monitoring, contact tracing, and public health risk adjustment.

In summary, NYeC looks forward to continued collaboration with CMS in advancing nationwide interoperability, improving healthcare delivery and health of our communities, and facilitating patient access to their health information.

Sincerely,

Valerie Grey
Executive Director

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[1] https://www.hhs.gov/about/news/2020/06/04/hhs-announces-new-laboratory-data-reporting-guidance-for-covid-19-testing.html