**Valerie Grey**
**Chief Executive Officer**

June 28, 2021

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

*Re: CMS-1752-P: 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 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program*

Dear Administrator Brooks-LaSure,

The New York eHealth Collaborative (NYeC) is pleased to provide these comments in response to the Inpatient Prospective Payment System Proposed Year 2022 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 is a public utility that 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 health information exchange to transform healthcare.

During the COVID-19 Public Health Emergency, Health Information Exchanges and Networks (HIEs/HINs) such as the SHIN-NY have demonstrated their large role in advancing public health outcomes and will continue to improve both the quality and value of healthcare in the future. NYeC appreciates the opportunity to provide comments and input on the proposed rule. Highlights of our comment letter include:

- **Advancing Digital Quality Measurement RFI:** NYeC generally supports the movement to FHIR-based APIs, but believes that CMS should leverage existing infrastructure, including HIEs to continue to support quality measurement and reporting. HIEs have robust repositories of patient health data from sources beyond hospital EHRs and have the capacity to aggregate data

from across these sources to provide more consistent, accurate, and complete reporting. CMS should expand and establish policies and processes for data aggregation and measure calculation by third-party aggregators, such as HIEs, as they do in the MIPS Program.

- **Closing the Health Equity Gap in CMS Hospital Reporting Programs RFI:** Our experience responding to COVID-19 has revealed significant gaps in the capture and reporting of race and ethnicity data for several reasons. CMS can begin to address this problem by working across HHS and other federal agencies to improve the standards associated with race and ethnicity variables, increase resources for training and education for health care workers, and tie incentive payments to the successful capture of self-reported race and ethnicity data. As it works to address this problem, CMS should leverage HIEs to play a key role in enhancing and closing gaps in EHR demographic data. In addition to race and ethnicity, as standards become increasingly mature, NYeC encourages CMS to expand requirements to capture key social determinants of health (SDoH) data and work across federal agencies and the private sector to harmonize standards for patient address.

- **Medicare Promoting Interoperability Program**
    - *Prescription Drug Monitoring Program (PDMP) Measure*: CMS should continue to include this measure as optional. If it does finalize a requirement in future years for hospitals to query a PDMP through Certified Electronic Health Record Technology (CEHRT), NYeC suggests that CMS include an exclusion for hospitals, such as those in New York State (NYS), who are required by the state to use a process that exists outside of the hospital EHR.

    - *Health Information Exchange Bi-Directional Measure:* NYeC strongly supports CMS' proposal of an HIE bi-directional exchange alternative measure under the Health Information Exchange objective, with some clarifications.
        - Remove the word incorporating from the definition of bi-directional
        - Define widespread exchange or broad network to encompass a diverse array of stakeholders outside of traditional practices (i.e. LTPAC, behavioral health, pharmacies, community-based organizations (CBOs), labs etc.)
        - Provide incentives for non-Meaningful Use (MU), left-behind sectors to adopt health IT
        - Allow for multiple types of HIE connections to a hospital EHR, including clinical viewers and HL7 v2 feeds

    - *Electronic Clinical Quality Measures (eCQMs)*: NYeC strongly suggests that CMS wait until CY 2024 or later to require eligible hospitals and CAHs to submit data using only certified technology consistent with the 2015 Cures Act update.

In summary, NYeC applauds CMS for their continued commitment to improving quality, promoting interoperability, and demonstrating value in order to improve health outcomes. Our comments reflect NYeC's continued commitment to partnering with the Administration to develop policy solutions that will support a cohesive, nationwide strategy that leverages HIEs to enable secure, meaningful, and scalable data sharing across all sectors of care.

Sincerely,

Valerie Grey
Chief Executive Officer (CEO)
New York eHealth Collaborative

**Detailed comments:**

**Advancing to Digital Quality Measurement and the Use of FHIR in Hospital Quality Programs, Request for Information — Section IX(A)**

NYeC applauds CMS' goals to streamline its approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning.

NYeC generally supports the movement to FHIR-based APIs, as well as broad alignment with the interoperability landscape. However, while FHIR APIs have the capability to advance interoperability, they do not yet adequately address the problem of aggregating data across the federated architecture of the US health care system, which may include thousands of data sources and systems. Not all of these data sources are equipped at this point to send FHIR data to an API. It will take considerable resource investment, coordination, standards development, and most of all a foundation of meaningful, complete, and accurate data to make FHIR work for quality measurement in the way CMS envisions.

As such, provider FHIR-based APIs should not be used in a vacuum or as the only mechanisms for data collection and reporting. NYeC believes that CMS should leverage existing infrastructure, including HIEs to continue to support quality measurement and reporting. HIEs have robust repositories of patient health data from sources beyond hospital EHRs, including physician practices, post-acute care facilities, behavioral health, public health registries, payers, and social services. They have the unique capacity to ingest and aggregate data from across these sources and provide more consistent, accurate, and complete reporting. With more data sources from across the continuum of care, measure exclusions and numerator capture increases, resulting in more accurate calculation and capture of care delivery. HIEs provide the added capability of monitoring privacy and security, solving patient identity discrepancies, and strengthening the quality of the data exchanged.

We appreciate that CMS explicitly calls out HIEs as potential data sources and data aggregators and agree that CMS should expand and establish policies and processes for data aggregation and measure calculation by third-party aggregators as they do in the MIPS Program. Additionally, we believe that CMS should explicitly incentivize quality measure reporting via HIEs. Some examples of how SHIN-NY HIEs currently support quality measures include:

- Two Qualified Entities in the (HEALTHeLINK and HealtheConnections) are approved 2020 Qualified Registries, authorized by CMS to submit Quality Measures, Promoting Interoperability Measures, and/or Improvement Activities on behalf of MIPS eligible clinicians, groups, and/or virtual groups for purposes of MIPS for the 2020 performance year.
- One Qualified Entity (Bronx RHIO) has developed measure specifications and calculates over 40 clinical quality measures for quality-based organizations to assess measure performance at both the provider and payer level.

- Two Qualified Entities (HEALTHeLINK and Bronx RHIO) participated in a National Committee for Quality Assurance (NCQA) Digital Measure Pilot. They analyzed and calculated performance rates for 2 Electronic Clinical Data System (ECDS) measure specifications (Breast Cancer Screening and Colorectal Cancer Screening) and compared them to HEDIS/eCQM measure

specifications. With relaxed criteria, the HIEs calculated rates for both cancer screening measures that were comparable to nationally reported rates and both sites had the capacity to perform quality measurement calculations and report out.

- Based off prior grant funding, three Qualified Entities (Hixny, HEALTHeLINK, and HealtheConnections) were able to create provider-based user interfaces for quality measurement to inform real-time patient intervention.

- NYeC and NYS DOH collaborated with NCQA on a groundbreaking Data Aggregator Validation Program, which certifies an HIE to provide standardized supplemental data to health plans for HEDIS reporting, including Medicare Advantage and NYS Medicaid Managed Care Plans. Hixny, HEALTHeLINK, and HealtheConnections were the first HIEs in the nation to obtain a certification that demonstrates that they passed robust and rigorous data validation processes. The remaining HIEs in the SHIN-NY are preparing to proceed as well. This data validation alleviates the burden on health plans of having to perform their own audit of data received from an HIE and on providers from having to respond to data requests from health plans. We believe that an opportunity exists for CMS to leverage these NCQA processes and apply them towards data validation and audit requirements of third-party intermediaries.

- Finally, HEALTHeLINK has been approved by CMS as a "data aggregator" for Comprehensive Primary Care Plus (CPC+) and will be using Medicare Fee-for-Service (FFS) claims to create quality measures for providers in support of the CPC+ program. This is a great start, but we encourage CMS to expand access to claims data for providers via HIEs, including collaborating with states to incentivize sharing of Medicaid claims. This would further the ability of HIEs to support quality objectives and would have multiple benefits that are central to CMS's goals, including reducing long-term provider burden, ensuring data integrity, and promoting interoperability.

**Closing the Health Equity Gap in CMS Hospital Reporting Programs, Request for Information – Section IX(B)**

NYeC appreciates CMS' recognition of the role health disparities play in health outcomes and the commitment to advancing health equity by improving the collection of race and ethnicity and other demographic data. Accurately capturing this information is critical to informing effective treatment and patient care, improving risk scores in value-based care initiatives, properly allocating health care resources, and designing culturally appropriate interventions to improve health outcomes. 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.

CMS requests information on the challenges facing hospitals in capturing race, ethnicity, and other sensitive demographic data at the time of admission. Often, a major factor affecting the quality of data is the lack of understanding about how best to collect this information from patients. Further, the current standards that exist for capturing race and ethnicity data are insufficient and, in many cases, codify structural inequalities and biases. Variables can be difficult to define, especially considering many

individuals identify with more than one race and ethnicity. Finally, while certified electronic health record technology (CEHRT) systems must support the capture of this data, there is no requirement or incentive to actually collect it at the point of care. This lack of incentive combined with poor standards and a lack of resources for training result in low capture rates. CMS can begin to address this problem by working across HHS and other federal agencies to improve the standards and questionnaires associated with race and ethnicity variables, enhance training and education for health care workers, and tie incentive payments in the Promoting Interoperability Program or the Hospital Inpatient Quality Reporting Program to the successful capture of self-reported race and ethnicity data.

We understand this problem will take significant time, collaboration, and investment to solve. Addressing racial inequality gaps will require expanded code sets and HIE's can guide their participants through this change and play a key role in enhancing and closing gaps in EHR data. HIEs maintain integrated health data sets and their infrastructure and community partnerships allow them to address data quality with established change control processes.

Throughout COVID-19 the New York QEs have collaborated with the New York City and State Departments of Health to supply necessary data from electronic health records, including demographic data, to supplement electronic laboratory reports on COVID-19 positive, or presumed positive patients. The SHIN-NY continues to actively explore new ways to improve demographic data capture and exchange. One QE, the Rochester Regional Health Information Organization, recently received funding from the Greater Rochester Health Foundation for a two-year project to improve the quality and completeness of demographic data collected and shared in EHR systems across the region.

NYeC recommends that, as standards become increasingly mature, CMS expand incentives to capture key social determinants of health (SDoH) data, including housing instability, food insecurity, transportation barriers, and utility help needs, as well as sexual orientation and gender identity to identify the impact of social disparities. In 2020, the NYS Bureau of Social Determinants of Health worked with Health Homes on the Health Home Care Management Assessment Reporting Tool (HH-CMART) to implement components of [CMS's Accountable Health Communities Health Related Social Needs (HRSN) screening tool](). CMS should incentivize specific standards such as this and leverage the experiences of NYS Health Homes to inform the approach in capturing this information. CMS should also continue to work across federal agencies and the private sector to harmonize standards for patient address and engage in initiatives such as the [Gravity Project]() and [Project US@.]()

**Proposed Changes to the Medicare Promoting Interoperability Programs – Section IX(F)**

*Query of Prescription Drug Monitoring Program (PDMP) Measure*

We support CMS's proposal to extend the PDMP measure as optional in CY 2022 to allow time for further progress around efforts to integrate PDMPs into EHRs. 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 hospital'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.

If CMS finalizes a requirement in future years for hospitals to query a PDMP through CEHRT, we suggest that CMS include an exclusion for hospitals, such as those in NYS, who are required by the state to use a process that exists outside of the hospital EHR.

*Health Information Exchange (HIE) Bi-Directional Measure*

NYeC strongly supports CMS' proposal of an alternative measure for bi-directional exchange through an HIE under the HIE objective. We believe that greater use of HIEs for bi-directional exchange will immediately contribute to enhanced care coordination across settings. The SHIN-NY connects with all of the hospitals in NYS making it well positioned to support this measure for eligible hospitals and CAHs.

This new optional measure would require that bi-directional exchange occurs for all unique patients and patient records. NYeC requests clarification on whether bi-directional exchange includes incorporating data into the EHR. On page 25631 of the proposed rule, CMS explicitly mentions that bi-directional means that the hospital's EHR enables querying and sharing data by sending, receiving, and incorporating data via an HIE. However, later in the section, on page 25633, CMS only mentions querying/receiving and sending/sharing health information. NYeC recommends that this definition not include incorporating into the EHR because we believe hospitals should have flexibility to choose the mechanism for "incorporation" of information that best fits their workflow.

Additionally, NYeC suggests that CMS adopt metrics to define widespread exchange or broad network (as stated in the second attestation statement). Such metrics could be based on participation or usage, but should encompass a wide network of providers, including those not traditionally eligible for Meaningful Use. For example, CMS could define a broad network as one in which HIEs exchange data among a diverse array of stakeholders outside of traditional practices (i.e. LTPAC, behavioral health, pharmacies, CBOs, labs etc.). Because of this wide span and variation, particularly in resources, CMS could define a broad network as one that comprises a significant preponderance of the Medicare beneficiary's care based on the ability of the care team to receive a patient record through an HIE.

We strongly encourage CMS to consider policy levers and financial incentives to support providers in adopting certified EHRs and participating in the electronic exchange of health information, particularly the "left behind" sectors (i.e. long-term and post-acute care, behavioral health, and pharmacies) that were not eligible for Meaningful Use. Many post-acute (PAC) and home and community-based service providers (HCBS) avoid adoption of EHRs due to lack of resources, staff, and education or assistance on how to meaningfully use these products. Success in value-based care and health information exchange will require bringing a broader array of healthcare providers and non-traditional entities into the electronic data infrastructure fold. New York is 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.

Finally, CMS asks about the current state of hospital connections to HIEs through FHIR-APIs. While many HIEs, including the SHIN-NY QEs, are beginning to implement APIs for specific use cases, they are largely not being used to connect with hospitals today. NYeC believes CMS should allow for multiple types of HIE connections to a hospital EHR, including CCD and summary of care record transmission, hospital clinical viewers, and patient portals. Further, given CMS' recent Conditions of Participation requirement for hospitals to deliver event notifications, NYeC believes that CMS should allow for HL7 v2 connections to count for this requirement.

*Electronic Clinical Quality Measures (eCQMs)*

CMS asks for comment on the proposal to require hospitals to use only certified technology consistent with the 2015 Edition Cures Act Update to submit data for eCQMs beginning with reporting period CY 2023. We strongly suggest that CMS wait until CY 2024 or later to require eligible hospitals and CAHs to submit data using only certified technology consistent with the 2015 Cures Act update. We anticipate that many developers will not fully upgrade their technology until the compliance date of December of 2022 and therefore will only begin rolling out updates to hospitals near the beginning of 2023. Developers will then be busy with upgrades and it may take several more months to update all user systems. We believe that providing an additional, delayed phase-in period for hospitals and providers to update to the new certification criteria will ensure widespread participation and continuous growth across hospitals.