January 25, 2018

Donald W. Rucker, MD
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St, SW, Floor 7
Washington, DC 20201

RE: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.

Dear Dr. Rucker:

The New York eHealth Collaborative (NYeC) is pleased to provide these comments in response to the draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.

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.

NYeC supports the continued efforts of the Department of Health and Human Services (HHS), particularly the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS) to reduce provider burden and accelerate interoperability. NYeC is appreciative of the draft strategy, its overarching goals and its focus on making the use of health information technology (IT) and electronic health records (EHRs) seamless and effortless. We believe such is essential to ensuring health care providers utilize health information exchange (HIE) and the ultimate goal of better health care is achieved. As explained in greater detail herein, we encourage a focus on the following priorities to most effectively reduce provider burden:

- Leveraging standards and HIEs to assist with clinical documentation (e.g., prior authorization);
- Incentivizing developers to better user experience;
- Developing clear standards for Prescription Drug Monitoring Program (PDMP) workflow integration and nationwide connectivity;

- Aligning 42 CFR Part 2 with HIPAA to the greatest extent permissible under law and ensuring clear guidance to encourage sharing; and
- Continuing enhanced Medicaid federal financial participation for state health IT projects to lessen burden and advance interoperability.

Clinical Documentation

NYeC is supportive of efforts to leverage existing data to reduce re-documentation. We believe external data accessed by HIE should also be utilized to further support these efforts. Additionally, utilization of standards such as C-CDA for such exchange should be advanced as a best practice to prevent duplication and "note bloat." NYeC is supportive of waiving documentation requirements to provide the flexibility to test and administer alternative payments models (APMs). We also support continued stakeholder involvement to inform future documentation guideline modifications and remain an engaged stakeholder.

We support incorporation of best practices for reducing documentation burden into the technical assistance (TA) model as part of the Transforming Clinical Practice Initiative (TCPI) and believe use of the materials developed for this initiative should be available to the public to further promote these best practices.

NYeC also agrees with incentives for the adoption of technology to generate and exchange standardized data supporting the documentation needs for prior authorization and believes HIE can support this by ensuring the data providers need for prior authorization is available. Further, HIEs facilitate access to comprehensive clinical data on a patient, which can help avoid unnecessary or duplicate prior authorization requests for tests and procedures the patient may have already had.

Health IT Usability and the User Experience

NYeC is supportive of efforts to better align EHR system design with real-world clinical workflow, to improve clinical decision support usability, and to optimize user interface to improve efficiency. NYeC supports and encourages national advocacy efforts to encourage developers to build systems that improve presentation of clinical data, harmonize clinical content and provide a level of standardization in interface and workflow design for common clinical tasks that ultimately advance patient safety. NYeC is actively engaged in vendor advocacy on the state level and has seen results from these efforts. The strong unified advocacy of ONC and CMS can help influence system design, increase usability and reduce provider burden. With encouraging improvements to EHR system design, it is essential to ensure any costs from such advances do not get passed on to clinicians, as such could inadvertently impede access and interoperability efforts.

We continue to urge ONC and CMS to consider requiring hospitals to share admission, discharge, and transfer (ADT) data with other providers. New York hospitals currently do this through the SHIN-NY and it has proven to be a very valuable service that improves care and reduces costs. Integrating this clinical decision support into EHR systems through a connection with a HIE streamlines the communication and advances care coordination.

NYeC applauds ONC and CMS for their leadership in promoting nationwide strategies that further the exchange of electronic health information to interoperability and agree developers should continue to conform to the relevant standards. CMS should continue to push for open application programing interfaces (APIs) and providing patients electronic access to their health information.

Both efforts will help to accelerate interoperability overall. NYeC also believes widespread adoption of EHRs and participation in HIE is essential to success. CMS could also allow participation in the Trusted Exchange Framework and Common Agreement (TEFCA) to count towards meeting future interoperability requirements. We continue to urge CMS to reimburse providers for the underlying tasks that are required to enable interoperability. CMS should work with stakeholders to establish appropriate mechanisms by which providers can be compensated for the cost of creating interoperable data (i.e., creating structured data). To help incentivize participation and handle the varying readiness levels of different non-promoting interoperability provider types, CMS should phase in future interoperability requirements over time, moving initially from incentives to a firm requirement. This "on-ramp" approach mirrors other CMS programs such as the EHR Incentive Programs and Electronic Prescribing Incentive Program. NYeC also feels active participation in HIEs, as designated by the Medicaid agency in each state, should serve as evidence that information blocking, as defined by the 21st Century Cures Act, is not occurring. If this were included in the regulation expected to be promulgated soon, this would accelerate current HIE efforts and is especially important now, as TEFCA development, creation, establishment, and full implementation will take significant time.

EHR Reporting
NYeC strongly supports and encourages continuation of enhanced Medicaid federal financial participation to support state health IT projects. NYeC, as the SDE charged with the governance, coordination, and administration of the SHIN-NY, has been supported in large part through the Medicaid Promoting Interoperability (PI) Program 90/10 funding provided through the Health Information Technology for Economic and Clinical Health (HITECH) Act. With this funding NYeC has been successful in advancing interoperability statewide. The SHIN-NY, a "network of networks" consisting of eight qualified entities (QEs), also known as regional health information organizations (RHIOs), and a statewide connector, facilitates secure sharing of clinical data from participating providers' EHRs. New York State hospitals, home health care agencies, long-term home health care programs, and hospices that use certified EHR technology (CEHRT) are required to participate in and contribute a standard set of data to the SHIN-NY.

New York State is actively working to further advance interoperability beyond the PI incentivized provider types. We believe success in payment reform will require incorporating a broader array of health care providers and non-traditional entities into the electronic data infrastructure. Today participants include hospitals, clinics, labs, radiology centers, ambulatory physicians, home care agencies, nursing homes, long-term care facilities, public health departments, health plans, behavioral health providers, NYS DOH, and Federally-Qualified Health Centers (FQHCs), among others. All New York State hospitals and over 109,000 health care professionals are part of our network. By making it possible to immediately access and share data, the SHIN-NY helps streamline care and supports better patient experiences and outcomes, improving safety and lowering health care costs. NYeC's work through its public/private partnership with the NYS DOH is a prime example of how enhanced Medicaid federal financial participation for Medicaid Enterprise systems can be used to leverage and build upon current federal investments supported by Medicaid Promoting Interoperability Program funding.

NYeC supported the actions CMS took over the last year to align PI and the Merit-Based Incentive Payment System (MIPS). We also fully supported minimizing the burden of health care providers with a preference for electronic clinical quality measures. We believe that incentivizing electronic clinical quality measures will not only minimize the burden of health care providers, but also enable ongoing analyses to further refine, standardize, and consolidate quality measures. We

appreciate efforts to explore less burdensome approaches to electronic clinical quality measure (eCQM) but caution that the first-year test approach for new measures could cause confusion and ultimately increase burden. We applaud CMS' focus on streamlining measures and encourage further efforts to better align both what measures are reported, and how they are reported. NYeC also supports efforts to improve measures and ensure they are geared toward interoperability and focused on HIE. team-based care relies on information exchange and meaningful HIE should be recognized and incentivized.

We support HHS continuing to explore opportunities within existing reporting programs that reward innovative uses of health IT and advancements, including incentives to participate in activities that demonstrate advanced interoperability. We continue to support scoring approaches that prioritize participation in HIE and agree that incentivizing clinicians to participate in a health information network (HIN) as part of ONC's TEFCA, when it becomes a reality, will help advance interoperability. NYeC also supports HHS looking at innovative uses to further reduce burden by having federal agencies pull data directly from health IT to facilitate reporting. NYS has developed pilots as part of their State Innovation Model to further explore how HIEs can reduce provider burden, such as medical record reviews, and provide real time feedback on quality measures.

NYeC remains supportive of CMS requiring the use of 2015 Edition certified EHR technology beginning with the 2019 MIPS performance period. We support ONC efforts to coordinate stakeholders and focus on best practices for data mapping and integrity. NYeC is supportive of ONC's work with fast healthcare interoperability resources-(FHIR) based APIs and exploring how such standard could lessen burden. Additionally, we support the Draft U.S. Core Data for Interoperability (USCDI) and its potential use both within TEFCA and beyond.

Public Health Reporting
NYeC strongly supports federal efforts to improve interoperability between health IT and prescription drug monitoring programs (PDMPs) and encourages the coordination of a shared strategy and the adoption of common standards for integration into workflow. New York was an early PDMP leader through adoption of a 2012 law requiring electronic prescribing and mandating the query of the Internet System for Tracking Over-Prescribing (I-STOP) prior to prescribing a Schedule II, III, or IV controlled substance. I-STOP is presently queried by providers at a rate of over 18 million queries annually. These queries are not typically performed through the EHR, but through a state-secured portal supported by the state's Bureau of Narcotics Enforcement (BNE).

We agree that integration into the EHR workflow will lessen provider burden while also helping to ensure greater compliance with the New York State law aimed at preventing doctor shopping. NYeC is currently facilitating a regional pilot program to enable this integration, while also exploring options for scalable statewide integration, in which we believe HIE will play an integral role. We continue working closely with BNE to develop specifications and implementation guides. Considering the current state of integration, it is expected that comprehensive statewide implementation of PDMP query via CEHRT will take time to implement across all providers and EHRs in the state.

We are very appreciative of the federal financial support provided by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act and believe this funding is essential to facilitating this type of widespread integration. In addition to financial support, we feel the coordination of a national strategy and adoption of common standards are also essential to facilitate successful integration. Such common

standards will greatly assist states in implementing and will help ensure interoperability among states. I-STOP currently connects to PDMPs in 25 states and D.C. However, these connections require separate and distinct queries, which presents a burden in the workflow. Common standards for all PDMPs nationwide could ensure state-to-state connections remain and achieve integration into workflow.

NYeC remains concerned regarding provisions recently adopted by CMS requiring hospitals to query PDMPs via CEHRT by 2020. Based on CMS comments in the finalized rule, we feel further clarification is necessary to understand what is required for this measurement. We encourage CMS to continue to push integration and utilization of CEHRT to query PDMPs but are concerned the 2020 timeline is too aggressive. We note that the recently finalized physician rule failed to require the query of PDMPs using CEHRT and instead left such to be addressed in future rulemaking. Further, the SUPPORT for Patient and Communities Act requires PDMPs to facilitate integration into the workflow by 2021. NYeC believes the extension and harmonization to the 2021 date would enable a smoother transition, ensure providers are not unfairly penalized and provide time for the creation of the shared strategy and common standards.

NYeC supports HHS convening stakeholders to inventory and harmonize public health reporting requirements. We also coordinate a Provider Advisory Group that has recognized this as a critical issue and provides ongoing feedback. We remain an engaged stakeholder.

NYeC supports alignment of 42 CFR Part 2 with HIPAA. Understanding statutory barriers to full alignment and the failure of Congress to include such changes as part of the recently enacted SUPPORT for Patients and Communities Act, NYeC is appreciative of HHS activities to educate and encourage Part 2 sharing to the greatest extent permissible under current law. NYeC agrees that ready access to accurate, current guidance from HHS, coordinated across agencies overseeing these respective rules, could provide more clarity and encourage greater information sharing. We also believe that this cross-agency coordination provides an opportunity to better align Part 2 consent requirements with HIPAA in ways permissible under current law. Such administrative changes would further reduce confusion and increase sharing.

Thank you for the opportunity to provide comments. If you would like to discuss these issues further, please contact my assistant, Krissy Hines at khines@nyehealth.org or (518) 299-2321.

Sincerely,

Valerie Grey
Executive Director