



October 3, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
330 C Street, S.W.
Washington, DC 20201

Submitted electronically via: [Regulations.gov](https://www.regulations.gov) for [CMS-1734-P](#)

Re: CY2021 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule

Dear Administrator Verma:

On behalf of the Strategic Health Information Exchange Collaborative (SHIEC), which represents 81 health information exchanges and health information networks (HIEs) across the nation, we are thankful for this opportunity to provide our expertise and to be a part of the important conversation on updates to the Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP). SHIEC appreciates that the Centers for Medicare & Medicaid Services (CMS) gives extensive recognition in this proposed rule to the value HIEs add for providers and patients in driving care coordination through data exchange. SHIEC members share the goal of integrating health care and human services data to support improved outcomes, and welcome collaboration with CMS to help build upon the architecture that exists today.

As the unbiased data trustees for their communities, SHIEC member HIEs serve nearly 95% of the United States population and are critical to achieving better health and quality of life in America. HIEs uniquely provide community-level identity resolution and linking of data beyond certified electronic health record systems, including data from pharmacies, post-acute care, behavioral health, and social services. SHIEC strives to support HHS and other federal agencies both as a partner in, and a resource for advancing interoperability. The dedication, energy, and passion exhibited by SHIEC's member HIEs over the past 20+ years have laid the foundation for nationwide health data interoperability among whole communities and regions. As evidenced by millions of secure health care data transactions occurring daily within and between HIEs, SHIEC members are delivering innovative interoperability solutions that are providing real and documented value to patient care in their communities, states, and across the nation.

During the Public Health Emergency (PHE), HIEs have responded rapidly, and in some cases quickly pivoted service offerings to meet the growing and developing needs of their



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communities. We welcome the opportunity to share how HIEs are integral in public health and syndromic surveillance activities, including providing dashboards tracking utilization of ICU beds and ventilators to manage capacity.

SHIEC thanks CMS for responding with increased flexibility for health care providers given the PHE, particularly by delaying the MIPS Value Pathways (MVP) program. Changing benchmarks to the 2021 performance period is the right thing to do given the outlier year 2020 has been thus far. By relaxing timeframes and delaying proposed programs, this rule is responding to both the COVID-19 pandemic and the ongoing opioid epidemic facing our nation, while acknowledging serious shortfalls in health IT adoption and interoperability. The MPFS and QPP program are important policy vehicles for CMS to aid healthcare providers' transition to an evidence driven, value-based system of coverage that embraces connected care whenever appropriate.

Merit-based Incentive Payment System (MIPS) Program Updates, Including Promoting Interoperability Updates

SHIEC applauds CMS' increased efforts towards promoting interoperability in this proposed rule by including a new health information exchange measure for Eligible Clinicians (ECs). More incentives to use existing HIE infrastructure will result in more ECs participating in directed exchange, query-based exchange, and consumer mediated exchange of health care data. HIEs aim to help create true longitudinal care records and support improved care coordination by facilitating timely access to robust health information across care settings. CMS must continue to incentivize providers and HIEs doing this important work.

There are still some significant barriers to interoperability that need to be addressed in rulemaking. The PHE has exposed existing information blocking issues, whereby public health agencies, commercial laboratories, and large integrated health systems are not sharing data. We expect that the implementation of the ONC's Cures Act Final Rule and the new HIE Bi-Directional Exchange measure will help address this issue, but CMS should additionally issue guidance directed at health care entities it regulates to further emphasize the importance of refraining from information blocking in a pandemic.

Health Information Exchange Objectives: Engagement in Bi-Directional Exchange Through HIE

SHIEC strongly supports CMS' proposal of an alternative measure for bi-directional data exchange through an HIE under the Health Information Exchange objective.

Given that EC use of HIEs for bi-directional exchange will immediately contribute to a longitudinal care record for their patients and facilitate enhanced care coordination across

settings, SHIEC applauds this measure inclusion for CY 2021. SHIEC believes its member HIEs will be most successful at helping providers meet these important goals if this measure only remains optional for a calendar year and is included as a required measure in the forthcoming MIPS Value Pathway program. SHIEC strongly supports this measure since its engagement facilitates robust health information exchange without placing burden on the clinician or the patient to be individually accountable to facilitate exchange via multiple (and potentially unknown) point-to-point connections.

CMS proposes that the Bi-Directional Exchange measure would be worth 40 points. SHIEC agrees that fulfillment of this measure is an extremely high value action worth this weight.

To successfully attest to this measure, the eligible clinician must use the capabilities defined for Certified EHR Technology (CEHRT) to engage in bi-directional exchange via the HIE, which includes exchanging the clinical data specified in the Common Clinical Data Set (CCDS) or the U.S. Core Data for Interoperability (USCDI). This is consistent with both of the existing measures under the Health Information Exchange objective, which require the use of CEHRT to create a Consolidated Clinical Document Architecture (C-CDA) document and includes the clinical data within the CCDS or the USCDI. SHIEC supports the CMS proposal that health care providers participating in the Promoting Interoperability Programs (PI) or QPP be required to use only technology that is considered certified under the ONC Health IT Certification Program according to the timelines finalized in the ONC Cures Act Final Rule.

HIEs are currently interacting with health care providers using certified health IT in a variety of ways; and so SHIEC appreciates that CMS allows for substantial flexibility in how health care providers use certified health IT to exchange data using HIE. The flexibility provided in the proposed rule by CMS allows for maximum expansion of interoperable health IT and data exchange and is likely to result in more ECs using HIEs in their communities. More guidance from HHS on how the ONC Cures Act Final Rule, the CMS Interoperability and Patient Access Final Rule and the Quality Payment Program intersect would prove invaluable. Allowing for more synergy between the agencies' disparate rules and programs is necessary to reduce burdens placed on providers across multiple settings.

SHIEC supports the CMS proposal that the HIE Bi-Directional Exchange measure be reported by attestation that would simply require a yes/no response. SHIEC believes these statements reflect appropriate expectations about information exchange capabilities for eligible clinicians that engage with HIEs capable of facilitating widespread exchange with other health care providers.

As a collaborative organization, SHIEC is in a unique position to offer insight into the best practices for CMS to identify HIEs that can support the widespread exchange with other health

care providers. Our members have all levels of integration into the current health care delivery system and we encourage CMS to use our collaborative and our member HIEs as a primary resource to identify leaders within the field.

With quick adaptations, HIEs were able to offer targeted services for the COVID-19 response including positive test notifications to include automated near real time alerts to test results. Other responses by HIEs included emergency department tracking, including admissions, discharge, and transfer event notifications, capacity tracking, and real-time reporting to state and local health departments.

One SHIEC member, The North Carolina Health Information Exchange Authority (NC HealthConnex), is already working with the Division of Public Health to build bi-directional data exchanges and patient matching services between NC HealthConnex and the state's electronic disease surveillance systems, NC Electronic Disease Surveillance System and NC Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT), to better monitor the ongoing impact of COVID-19 in North Carolina.

For the NC EDSS team, NC HealthConnex is providing patient matching as a service and working to automate the inclusion of clinical data along with enhanced demographic data for the cohort of positive patient panels. They built a solution called Enterprise Entity Resolution that leverages other demographic data sets available to state government just for the purposes of person matching. The EER utility performs data standardization and cleansing of hundreds of millions of data records that have been collected over time and links a person's personal identifying information with a common ID using advanced analytic algorithms, while also maintaining the person's administrative system IDs. Currently more than 233 million records associated with 12 different data points have been integrated within EER. A few examples of utilities developed include answers to questions like: "What is the most current address reported to a government agency?", "Is this person deceased?", and "How do I link a HIE MPI to a Public Health person record?"

SHIEC members are also developing public health dashboards to enable health care providers to identify emerging trends and at-risk populations to support operations and point of care decisions. Directed exchange is also being used for sending immunization data to public health organizations or to report quality measures.

Quality Payment Program Proposals CY 2021

SHIEC would like to reiterate support for programmatic delays due to the PHE, as they will help support clinicians on the front lines by providing burden relief due to extreme and uncontrollable circumstances. SHIEC also vigorously supports this rule proposal to add a new fifth guiding



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principle pointing to an important Meaningful Measures element of the future vision for reducing MVP reporting burden; the use of digital performance measure data submission technologies to reduce provider burden.

Since Digital Quality Measures (dQMs) originate from sources of health information that are captured and can be transmitted electronically via interoperable systems, SHIEC believes that HIEs are in the best position assist providers in implementing and exchanging dQMs.

HIEs already help address issues with disorganized, duplicate, and incomplete data as a problem for public health, which have been exacerbated by the PHE. HIEs are capable of working with different independent provider associations with specific quality measure requirements. SHIEC member HealtheLink, an HIE that covers Western New York and is part of the state's Statewide Health Information Network, began waiving the requirement for patient consent prior to delivering COVID-19 test results to providers who have previously treated the patient. Nevada's HealthIE began offering free access to its provider portal, which contains medical records from all state residents. Nebraska Health Information Initiative partnered with the state's health department to deploy a COVID-19 data-monitoring platform. Michigan Health Information Network Shared Services teamed up with the Michigan Department of Health and Human Services to expand the number of patients it covers throughout the state. The HIE added Detroit Medical Center, Trinity Health System and Henry Ford Health System to its network.

DQMs can mine standard clinical data elements generated at the point of care from electronic sources as well as data from payers, including the use of claims and clinical data to identify patients at high risk for COVID. This reduces the burden on frontline clinicians and teams, and eliminates burden associated with manual chart abstraction and interpretation of unstructured data. CQL facilitates the expression of complex logic statements and calculations, which reduces the work associated with reporting of results. Finally, dQMs also limit the need for post-reporting error evaluation, especially when coupled with a more rigorous certification process.

SHIEC supports the inclusion of dQMs to support infrastructure development for public health informatics. State and regional HIEs typically obtain not just EHR-generated data, but a broader array of event notification and lab feeds as they build on local relationships and have similar but not identical capabilities with several models of data storage and a variety of business models.

To further support optimal care coordination, SHIEC encourages the inclusion of diagnosis codes, along with the chief complaint for patient presentation, as part of the ADTs. Both pieces of information are critical for providers, care coordinators and payers to timely respond to a patient presentation to an emergency room.

SHIEC encourages CMS to provide funding proposals to help rural and critical access hospitals that lack the technical, human, and financial resources to do the work. SHIEC also supports the requirement that psychiatric hospitals send event notifications to organizations that can facilitate health information exchange.

Local Health Departments (LHDs) will need to participate in health information exchange with a number of partners in order to benefit from these data resources including the laboratory encounters, demographics, diagnoses, and imaging data available through the HIEs which have a wide range of potential benefits to public health, including disease reporting, outbreak surveillance, and population health monitoring. Also notable are epidemiologic, disease surveillance, and/or community assessment gains, and improved disaster response capabilities from this participation. But currently, compared with other forms of public health informatics—including immunization registries, electronic disease reporting systems, electronic laboratory reporting, and EHRs—HIEs are the least commonly used information system by LHDs. The challenges to adoption of robust data exchange at the local health dept level include HIPAA, privacy or legal concerns; lack of or access to technical support or expertise; and exchange partners not having the ability, interest, or incentive to electronically exchange health information.

SHIEC supports CMS removing obstacles such as insufficient information on exchange options available such as exchange partners, transport mechanisms; lack of support from leadership; and limited broadband/internet access. Public health information system integration with HIEs produces improvements in assessment and planning, case management, care coordination, preparedness, surveillance, and workplace efficiency. Investments in the public private partnership will help realize major gains in public health.

Telehealth and Other Services Involving Communications Technology

SHIEC appreciates CMS's articulation of the type of information the agency seeks to inform decisions to cover Medicare telehealth services on a permanent basis. As the industry moves forward from this PHE, telehealth should be considered for all cost base measures. It is important to include telehealth as it relates to any episode-based measure for patient care continuity.

States' varied interpretation of privacy laws is also a considerable obstacle to interoperability nationwide. CMS highlights in this proposed rule that HIEs can specifically support the PHE response by enabling enhanced use of telehealth and telemedicine for obtaining and aggregating patient information including when the patient's health care provider(s) may not be known. In response to the PHE, CMS has taken steps to significantly expand access to services



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via telehealth, by increasing flexibility, and with HHS OIG, extending enforcement discretion to non-HIPAA compliant telecommunication apps.

HIEs already support bi-directional information exchange, push/pull and query/response functionality, provider and payer portals, download and single-sign-on EHR integration capabilities, delivery of event notifications and clinical results notifications in both human and machine readable formats, secure email for clinical information exchange; public health reporting, connections for immunization registry, electronic lab reporting, syndromic surveillance and disease registries, all while remaining HIPAA compliant. HIEs have the capacity to ensure that the data reaches those organizations who are allowed and able to use it.

HIEs can support patient care by ensuring health care providers are able to access patient data in support of a telehealth encounter or subsequent in-person visit with either an established or new health care provider. Particularly for visits with a new health care provider, the HIE may provide an option for health care providers to access critical health information. In addition, HIEs can support telehealth visits for screening, evaluation, and event notification for care team members for patients that have been exposed, tested, and quarantined or isolated. HIEs can ensure information about testing results is available to support the immediate and longer-term health and clinical needs of an individual.

All nonprofit statewide and community based HIEs are vendor agnostic, and policies surrounding communication technology-based tools must be agnostic as well to allow for incorporation of innovation and new evidence-based digital tools. Per CMS, “telephones, facsimile machines, and electronic mail systems” are relics of a non-secure and rudimentary communications system. Patients have rightly come to expect far greater data security and often possess the technology necessary to secure their data even when the originating site of a telehealth encounter is the patient’s home. CMS should prioritize access to high speed internet for patients in remote care settings and stop prioritizing faxes. We support CMS’ definition of an interactive telecommunication system as “multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication.” In this proposed rule CMS states the intention to delete the confusing reference to “telephones, facsimile machines, and electronic mail systems” as impermissible technology in the definition of an interactive telecommunications system. We agree that this reference creates confusion about use of eligible devices such as a smart phone or even an interactive telehealth platform operating within an electronic health information system. Patient and client preferences support use of communication technology-based tools and SHIEC recognizes that privacy and security cannot be used as excuses to drive market share or limit access to only one connected health tool.



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Value-based care requires interoperable, longitudinal patient data in a broad ecosystem of shared health information. It is particularly noteworthy that this proposed rule continues to build upon and advance patient-centered digital, interoperable, connected healthcare in several areas, including telehealth service coverage, virtual substance use disorder treatment provisions, and the MVP Program. QPP will remain an essential component to advancing interoperability to ensure provider and patient access to the critical information needed for health care delivery, improvement, and decision making.

While there is nothing in the QPP that explicitly prevents interoperability, SHIEC encourages CMS to continue to develop QPP to advance health information exchange, which is at the core of a patient centered, interoperable health care system. We ask CMS to include this proposed new Bi-Directional Exchange measure as well as develop additional PI measures for QPP to further these goals. SHIEC encourages CMS to explore how these measures and outcomes can be fully integrated into the MVP Program, to build on the important policy and technological advances in information exchange. We look forward to the opportunity to discuss these issues in more depth at your convenience.

Thank you for the opportunity to provide input on the CY 2021 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule. If you have any questions or if SHIEC can be of assistance, please feel free to contact me at melissa.kotrys@healthcurrent.org or (602) 688-7201.

Sincerely,

A handwritten signature in black ink that reads 'Melissa A. Kotrys'. The signature is written in a cursive, flowing style.

Melissa A. Kotrys, MPH
Chair, SHIEC Board of Directors