



June 28, 2021

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

Submitted electronically via Regulations.gov for CMS-1752-P

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 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,

On behalf of the Strategic Health Information Exchange Collaborative (SHIEC), which represents 83 health information exchanges (HIEs) and Associated Organizations across the nation, we appreciate every opportunity to provide feedback on proposed changes to requirements around the sharing of payer data. **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.** We submit this letter to illustrate the importance HIEs place on public health. 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.

HIEs are already engaging in the important interoperability work that aligns with many provisions of the proposed rule. In addition, **HIEs are actively assisting payers and providers in complying with other federal and state requirements, including compliance with CMS' and Office of the National Coordinator for Health IT (ONC) final interoperability rules, corresponding admission, discharge, and transfer (ADT) event notifications through CMS Conditions of Participation, state prescription monitoring programs, and other initiatives.** SHIEC's member HIEs serve 92% of the United States population and power the nationwide interoperability framework for ADT alerts—called Patient Centered Data Home (PCDH)—which notifies a patient's home care team of an ADT event no matter where in the United States the care occurred.

By serving as a hub of health information for their communities, HIEs apply data standards across communities by leveraging connections with providers, payers, pharmacies, public health organizations, state entities, and other stakeholders to distribute necessary information across HIE participants. For this reason, and because the core functions of HIEs include standardizing patient matching, event notifications, consent management, transmitting data for care coordination, and other technical data alignment, CMS should consider HIEs central to community data exchange. **We believe that CMS' payment, interoperability, and data exchange policies should leverage HIEs to enable secure, meaningful, and scalable data sharing across all communities.**

We have collected feedback from our membership on the proposed rule here and welcome an opportunity to discuss these comments in more detail with CMS.

Comment Overview:

1. Promoting Interoperability Program Updates

- *Health Information Exchange Bi-Directional Measure*
 - SHIEC strongly supports CMS' proposal of an alternative measure for bi-directional data exchange through an HIE under the Health Information Exchange objective.
 - SHIEC supports the CMS proposal that the HIE Bi-Directional Exchange measure be reported by attestation that would simply require a yes/no response.
 - CMS should consider clarifying the definition of bi-directional exchange to mean either: (1) sending, receiving, and incorporating; or (2) using a portal or clinical viewer that is integrated into the EHR clinical workflow.
 - SHIEC strongly encourages the U.S. Department of Health and Human Services (HHS) to implement and enforce regulatory requirements that hospital EHRs support integrated bi-directional exchange without imposing additional costs on hospitals.
 - SHIEC supports the proposal that eligible hospitals and critical access hospitals (CAHs) use certified technology to support exchange under this measure; however, we suggest providing clarifying information on if the use of a hospital clinical viewer would satisfy this measure.
 - CMS should consider differentiating between state/regional HIEs and technology networks, and encouraging hospital participation in state/regional HIEs, because it will lead to more inclusive, comprehensive, and beneficial bi-directional exchange.
- *Prescription Drug Monitoring Program (PDMP) Measure*
 - SHIEC supports CMS' proposal to increase the PDMP measure bonus to 10 points and to make this measure required in future program years.
 - SHIEC recommends that CMS explicitly incentivize PDMP integration with HIEs for this measure except for when/if HIE connectivity would interfere with other state level initiatives that are already in place.

2. Advancing Digital Quality Measurement (dQM) — Request for Information

- SHIEC supports the goal of using provider, FHIR-based APIs to support quality measurement but cautions that additional investment, guidance, and enforcement is needed before FHIR APIs can be used to support quality measurement in the way CMS envisions.
- HIEs are extremely valuable tools and mechanisms in obtaining data needed for quality measurement and should be incorporated into every aspect of CMS' vision for digital quality measurement (please see examples in this section).

3. Closing the Health Equity Gap in CMS Hospital Reporting Programs – Request for Information

- CMS should work across agencies and with the community to explore expansion of existing categories of race/ethnicity within the existing OMB standard.
- HIEs are uniquely situated to fill in gaps relative to race, ethnicity, and other demographic information (please see examples in this section).

Detailed Comments:

1. Promoting Interoperability Program Updates

HIE Bi-Directional Exchange Alternative Measure

SHIEC strongly supports CMS' proposal of an alternative measure for bi-directional data exchange through an HIE under the Health Information Exchange objective and appreciates CMS' consideration and inclusion of HIEs in a national interoperability solution. More incentives to use existing HIE infrastructure will decrease cost and provider burden and result in more Eligible Hospitals and Critical Access Hospitals participating in interoperability and consumer access. SHIEC recognizes that HIE coverage and access varies by state and region; however, throughout most of the country, HIEs exist that can support impacted hospitals in meeting the new HIE Bi-Directional Exchange alternative measure.

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.

SHIEC also has four suggestions for enhancing the goals of the HIE Bi-Directional Exchange measure:

First, CMS should consider clarifying the definition of bi-directional exchange to mean either: (1) sending, receiving, and incorporating; or (2) using a portal or clinical viewer that is integrated into the EHR clinical workflow. This definition is more descriptive of the technical solutions available for bi-directional exchange.

Second, in order to realize the benefits of bidirectional data exchange, SHIEC strongly encourages HHS to implement and enforce regulatory requirements that hospital EHRs support integrated bi-directional exchange without imposing additional costs on hospitals. This is needed because many EHRs are not able to support integrated bidirectional exchange at this time.

Third, SHIEC supports the proposal that eligible hospitals and CAHs use certified technology to support exchange under this measure; however, we request clarification on whether the use of a hospital clinical viewer would satisfy this measure. HIEs are open to additional federal guidance and requirements for interoperability to meet federal certification requirements for participation in the programs described in this proposed rule.

Fourth, CMS should consider differentiating between state/regional HIEs and technology networks, and encouraging hospital participation in state/regional HIEs, because it will lead to more inclusive, meaningful, and beneficial bi-directional exchange. The proposed measure appears to allow hospitals to meet this measure by connecting to a technology network, like Carequality, without also participating in a local/regional HIE. While technology networks are undeniably important in this space, many healthcare organizations either connect to their state/regional HIE or, if they have not already, could benefit from doing so. Many smaller safety net providers, especially ambulatory providers, participate in state/regional HIEs, but not directly in technology networks. So, by allowing hospitals to satisfy the bi-directionality measure through connectivity with technology networks only, hospitals may be missing connections with those providers that are connected to a state or regional HIE. Patients would benefit the most by having more comprehensive bi-directional data exchange as they move through the healthcare system.

Moreover, many state/regional HIEs participate in national networks, like PCDH, such that hospitals (and patients) gain the benefits of state, regional and national bi-directional exchange through hospital participation in a state/regional HIE. CMS should thus consider limiting this measure to hospital connections to state/regional HIEs. This creates an incentive for hospitals to connect to providers and other healthcare organizations in their community and allows them to benefit from the extensive advantages of participating in an HIE.

SHIEC further contends that CMS could differentiate between state/regional HIEs and technology networks by defining HIE. The inclusion of an HIE definition in the IPPS final rule would not only clarify the difference between these two entity types but would also allow organizations to better understand if their existing connection supports compliance. For example, CMS could define an HIE as:

“A non-profit entity with broad representation on its governing board and broad participation from public health, hospitals, physicians, health plans, long term and post-acute care (LTPAC), behavioral health, social service organizations, pharmacies, etc., in a particular region or state or set of regions or states. In addition, HIEs are generally mission-driven organizations whose mission includes promoting better health information sharing throughout a specific region.”

Conversely, technology networks are non-stakeholder entities that purely serve to set standards and policies and provide services enabling secure health information sharing.

HIEs are increasingly pivoting to become health data utilities and have increasingly demonstrated their value in providing robust services beyond just clinical document exchange, especially during the COVID-19 pandemic. Incorporating HIEs into the model supports this pivot for them to become health data utilities for other purposes, creating the opportunity for administrative and fiscal efficiencies by repurposing the HIE infrastructure for additional activities.

Throughout the pandemic, HIEs were able to offer targeted services for the COVID-19 response including near real time alerts on positive test notifications to state and local health departments, emergency department and capacity tracking, reporting of quality measures, and sending of immunization data to public health organizations. 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.

For example, the Indiana Health Information Exchange (IHIE), in collaboration with the Indiana State Department of Health (ISDH), has been able to provide public, real-time updates of COVID-19 testing results through correct testing, coding, and data processing of critical information at the time of care and by connecting labs with electronic health information exchange. In addition, IHIE is working to deploy a visual data dashboard for ISDH and public health departments to display snapshots of key indicators that all healthcare professionals should be made aware of to promote informed decision making when treating populations and patients.

In Vermont, Vermont Information Technology Leaders (VITL), created daily reports for the Department of Health to assist with identification of COVID-19 cases and hospitalized patients to monitor utilization and capacity. They were able to automate collection of around 40 data elements, saving manual work by hospital teams and improving data consistency. They also led a data quality effort with their 14 hospitals

to ensure the data was complete and accurate. This data was also used to inform a number of endpoints, including HHS, EMResource, Vermont's state dashboard, and reporting for state leadership.

The Health Collaborative in Ohio was instrumental in providing both data and non-data driven emergency response and coordination efforts for their region. They provided data solutions to the community through a growing, evolving dashboard of geographic maps to pinpoint where COVID breakouts were taking place, hospitalizations, ICU admissions, capacity planning, ADT alerts, and even data-validation with the state Department of Health. Non-data initiatives included pulling together a Multi-Agency Coalition (MAC) committee made up of diverse stakeholders from across the state, serving the community as a distribution center for PPE, ventilators, and mobile beds, and leading the efforts in selecting an alternative care hospital for overflow patients in the event of a surge.

These examples illustrate the crucial role that state and regional HIEs serve in supporting healthcare providers, state and local public health agencies, and other health care stakeholders across the country and underline the need to incorporate HIEs into every aspect of CMS' interoperability strategy.

Prescription Drug Monitoring Program (PDMP) Measure

SHIEC supports CMS' proposal to increase the PDMP measure bonus to 10 points and to make this measure required in future program years.

SHIEC recommends that CMS explicitly incentivize PDMP integration with HIEs for this measure with the exception of when/if HIE connectivity would interfere with other state level initiatives that are already in place. PDMPs have been enacted in all 50 states, enabling states to better track inappropriate requests for controlled substances, identify patients at-risk for substance use disorder, and to allow healthcare providers to intervene before a negative health outcome may occur.

The net results in most states that have employed PDMPs is decreased instances of drug abuse and increased individual-level care coordination. These results can be expanded on further by requiring PDMPs to integrate with the local or statewide health information exchange.

While some PDMP integration systems are cost prohibitive, there are multiple cost-effective methods of connectivity available to many HIEs, including FHIR, which allow for greater standardization and interoperability to reduce the burden of providers from having to access an external system.

While Nebraska was the first state to operate a PDMP on an HIE platform, other states have followed suit after recognizing the significant improvements that come with integration. In Nebraska, integration not only led to greater health outcomes for a state's patient population, but it also led to increased reporting capabilities, expanded use of PDMP to report all dispensed prescription drugs as opposed to only controlled substances, medication reconciliation, lower adverse drug events, reduced readmissions, and increased patient safety.

2. Advancing Digital Quality Measurement (dQM) — Request for Information

SHIEC supports the goal of using provider, FHIR-based APIs to support quality measurement. As is mandated in the 2020 CMS Interoperability and Patient Access Final Rule, certain CMS-regulated payers are required to use FHIR-based APIs to streamline a patient's access to their own information and patient-directed payer-to-payer exchange. This initiative showed the value in using FHIR-based APIs to efficiently query and send information between entities in a uniform method and in a standard format. This



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model could and should be mimicked in the quality space to allow for streamlined sharing between providers and payers.

While the FHIR standard is extremely valuable, it is currently not being used at the level needed to support quality measurement in the way CMS envisions. In order to realize the benefits of FHIR APIs, the following steps should be pursued:

- Additional investment in data sources to be FHIR-enabled;
- Additional regulatory guidance on FHIR specifications and requirements to support digital quality measurement; and
- Additional enforcement measures on use of FHIR specifications and implementation guides, including enforcement for EHR system conformance.

HIEs are valuable tools and mechanisms in obtaining data needed for digital quality measurement and should be incorporated into every aspect of CMS' vision for digital quality measurement. Quality measures calculated using single-site EHR data may be limited by incomplete information. HIEs allow for data sharing and collection from multiple sources outside of a hospital EHR, which significantly changes quality calculations and improves healthcare payments, patient safety, and care quality. dQMs should prioritize ingesting data from HIEs and incentives should be structured accordingly for hospitals to participate in HIEs for this purpose.

HIEs are currently supporting quality measurement for their payer community in a variety of ways. For example, Michigan Health Information Network (MiHIN) has supported its payer community extensively in supporting providers attesting to various quality programs by:

- Aggregating data on behalf of the providers to support their submissions;
- Working with the payers to help identify gaps in care and providing that information back to providers to close gaps;
- Actively helping payers improve their HEDIS scores;
- Saving payers time and resources by facilitating one connection to get access to clinical information from across the state; and
- Driving data quality improvements in conjunction with the payers in Michigan

Michigan has also supported its payer community in the quality measures space through assistance with the former Meaningful Use (MU) and current Promoting Interoperability (PI) program. Under MU (now PI), CMS mandated the EHR vendors calculate eQMs in the format of QRDA. MiHIN built Clinical Quality Measure Reporting and Repository (CQMRR) to validate, process, and display those eQm results for Michigan Medicaid.

In a related activity for HEDIS, MiHIN built the PPQC (Physician- Payer Quality Collaborative) infrastructure with the major payers, POs, and health systems in which they standardized the format used to transmit supplemental clinical data and gaps in care information.

SHIEC also supports the aggregation of data from multiple sources to inform measurement and potential policy considerations. If a model similar to the requirements of the CMS Interoperability and Patient Access Final Rule (information exchange through FHIR-based APIs) is utilized for the quality space, this could lead to more comprehensive and accurate measurements. For example, in Michigan, MiHIN took

on the role of aggregating data from multiple entities and converted all relevant data into a FHIR format. This allowed for a unique scenario, where all relevant information was in one location and in one format. This not only allowed for compliance with the federal requirements, but it also allowed for a scenario where this information could be repurposed for other public health or quality activities.

In Ohio, The Health Collaborative (THC), is the data aggregator, Quality Improvement/Practice Coaching, and Learning and Diffusion contractor for the CMS Innovation Center's Comprehensive Primary Care Plus model in Ohio and parts of Northern Kentucky. They also initiated a variation of the program, called Ohio-CPC, aimed at an additional set of measures driven at the State level, with participation from Medicare, Medicaid, and commercial payers. Overall, THC produces drill-down dashboards supporting quality, cost, and utilization measures for both the payer community and the primary care provider community, along with gaps in care metrics and detailed data.

CMS should encourage participation in an HIE in order to improve comprehensive information in quality reporting. HIEs can aggregate data from multiple sources, which resolves gaps in the current information that providers submit. Today, many providers have access to limited quality information. For example, if a provider only has their own EHR data, the quality measure reporting would be incomplete, as patients may have received services at other providers, who use other EHRs. Connection to an HIE would minimize the prevalence of these gaps because the aggregated HIE data would allow providers to include all reportable instances in their measure numerators. In Kansas, The Kansas Health Information Network (KHIN) published research in the Journal of the American Medical Informatics Association (JAMIA) showing that quality measures calculated using single site EHR data was limited by incomplete information, and furthermore, effective data sharing, such as HIE participation, had a determinative effect on healthcare payments, patient safety, and care quality.¹

3. Closing the Health Equity Gap in CMS Hospital Reporting Programs — Request for Information

SHIEC recognizes the need for more representative standards for race/ethnicity. CMS should work across agencies and with the community to explore expansion of existing categories of race/ethnicity within the existing OMB standard.

HIEs are uniquely situated to fill in gaps relative to race, ethnicity, and other demographic information. As is well documented in the public health space, both race and ethnicity can have a determinative impact on risk of developing and treating numerous medical conditions. Furthermore, race and ethnicity information is important for public health entities who may begin to consider how to best allocate resources to support communities who may be at a higher risk for certain conditions. HIEs can be valuable in this space because they serve as a centralized hub for health information sharing, meaning they can impose uniform requirements on data fields for race and ethnicity to the participant organizations who may be connected to them. Many are also able to work with state and public health entities to facilitate a dialogue on how to improve on the collection of these metrics.

Additionally, it would be challenging to gather accurate and complete race and ethnicity data by using a single source of information. HIEs can remedy this concern by combining and aggregating data from multiple sources. For example, Vermont utilized their HIE to address race and ethnicity relative to the COVID-19 pandemic. Early in the pandemic, Vermont Information Technology Leaders (VITL) worked with the Vermont Department of Health to provide access to its web-based provider portal to the state's

¹ D'Amore, J.D., McCrary, L.K., Denson, J., Chun, L. et al. *Clinical data sharing improves quality measurement and patient safety*. Source: <https://academic.oup.com/jamia/advance-article/doi/10.1093/jamia/ocab039/6169467>

infectious disease epidemiology team. This access allowed the epidemiology team to perform case investigation and reporting, removed the burden of manual data collection from providers, and allowed the epidemiology team to cross-reference medical records to gain more robust race information about COVID-19 cases in Vermont. At the end of March, prior to using the portal, race was unknown in 73% of cases. Through their joint work they were able to bring that number down to just 8%. Looking forward, the epidemiology team intends to use the portal to perform case investigation on all its reportable diseases.

Further, during the COVID-19 pandemic, the West Virginia Health Information Network (WVHIN) used demographic data from WVHIN's existing hospital and provider data feeds to reduce the percentage of unknown race and ethnicity classifications in COVID lab tests by half. WVHIN is currently working with the state to provide the same identification for vaccine administration, as well as providing geocoding so more targeted distribution can occur.

4. Supporting comment letters

A number of our HIE members, which are listed below, wish to add their individual support for the items raised in this comment letter. We would also like to draw your attention to the comment letters from other HIE members which have been separately submitted in response to CMS-1752-P, including from CyncHealth, Velatura Health Information Exchange Corp (VHIEC), Michigan Health Information Network (MiHIN), and the New York eHealth Collaborative (NYeC). As you will see, the SHIEC HIE community is deeply engaged in health information exchange and interoperability across the country, and we stand ready to collaborate to achieve the goals of this proposed rule.

Thank you for the opportunity to provide feedback and for your continued commitment to improving interoperability and health information exchange. If you have questions, please do not hesitate to reach out to SHIEC's interim CEO, Lisa Bari at lisa.bari@strategichie.com.

Sincerely,



Lisa Bari
CEO (Interim)
Strategic Health Information Exchange Collaborative (SHIEC)

SHIEC HIE MEMBERS WHO JOIN THIS COMMENT LETTER

Colorado Regional Health Information Organization (CORHIO)
CyncHealth (Nebraska and Iowa)
Delaware Health Information Network (DHIN)
East Tennessee Health Information Network (etHIN)
Georgia Regional Academic Community Health Information Exchange (GRACHIE)



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Health Current (Arizona)
Healthix (New York)
Indiana Health Information Exchange (IHIE)
Los Angeles Network for Enhanced Services (LANES)
Manifest MedEx (California)
Michigan Health Information Network (MiHIN)
Midwest Health Connection (Missouri)
MyHealth Access Network (Oklahoma)
The Health Collaborative (Ohio)
Reliance eHealth Collaborative (Oregon)
Rhode Island Quality Institute (RIQI)
Velatura Health Information Exchange Corporation (VHIEC)
Vermont Information Technology Leaders (VITL)
West Virginia Health Information Network (WVHIN)