June 25, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted electronically at: www.regulations.gov
Attention: CMS-1694-P

Centers for Medicare and Medicaid Services:

Thank you for the opportunity to provide a response to CMS-1694-P. The Minnesota e-Health Initiative is pleased to submit comments focused on two sections: 1) Proposed Changes to the Medicare and Medicaid EHR Incentive Programs and 2) Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare and Medicaid-Participating Providers and Suppliers.

We appreciate the work done to date by CMS to advance e-health to improve individual and population health. The Minnesota e-Health Initiative recognizes the value in advancing effective use and interoperability across the care continuum. We support actions to assure there is a system where an individual's health information is not limited to what is stored in electronic health records, but includes information from many different sources and provides a longitudinal picture of their health.

Please contact Kari Guida, Senior Health Informatician, Office of Health Information Technology, Minnesota Department of Health at kari.guida@state.mn.use with any questions.

Sincerely,

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Minnesota e-Health Initiative Statewide Coordinated Response to 2019 IPPS Proposed Rule

Minnesota e-Health Initiative and Advisory Committee

The Minnesota e-Health Initiative vision is that all communities and individuals benefit from, and are empowered by information and technology which advances health equity and supports health and wellbeing. For the past fourteen years the Minnesota e-Health Initiative, led by the Minnesota e-Health Initiative Advisory Committee and the Minnesota Department of Health's Office of Health Information Technology (MDH-OHIT), has encouraged and supported e-health across the continuum of care. As a result, Minnesota is a national leader in e-health stakeholder collaboration.

Minnesota e-Health Advisory Committee

The Minnesota e-Health Advisory Committee is a 25-member legislatively authorized committee appointed by the Commissioner of Health to build consensus on important e-health issues, and to advise on policy and common action needed to advance the Minnesota e-Health vision. The Committee is comprised of a diverse set of key Minnesota stakeholders, including: consumers, providers, payers, public health professionals, vendors, experts in health information technology, and researchers, among others. The committee co-chairs are Alan Abramson, Senior Vice President, IS&T and Chief Information Officer, HealthPartners and Bobbie McAdam, Vice President, Information Technology, Medica.

Workgroups

Committee members participate in workgroups to address detailed topics such as privacy and security, health information exchange, and standards and interoperability. The workgroups are the primary vehicle for receiving public input and investigating specific e-health topics through discussion and consensus building. The workgroup co-chairs and participants contribute subject matter expertise in discussions, research, and analyses through hundreds of hours of volunteer time. MDH-OHIT staff facilitate meetings, analyze and interpret data, and summarize findings that help support e-health policy development.

Statewide Coordinated Response Approach

This Minnesota e-Health statewide coordinated response to the request for public comment gathered input from multiple stakeholders, including the Advisory Committee and workgroups. Representatives from Minnesota health and health care providers and health care systems were encouraged to submit written comments and/or participate in one conference call hosted by MDH-OHIT. Comments were collected, summarized and reviewed.

Comments and Recommendations on the Proposed Changes to Medicare and Medicaid EHR Incentive Programs

Overall Comments

1. We applaud the effort to align the various federal programs. We strongly encourage ongoing resources for states and providers, and actions by federal programs and partners, to harmonize the federal programs' objectives, measures, and workflow implications for providers and states.
2. The State of Minnesota's MEIP has stated that it will work to align with the proposed rules to lessen the burden and confusion to implement the Promoting Interoperability (PI) Program. Nonetheless, resources should be provided to states to address the barriers and challenges of this alignment, the additional education and training needed for providers and states, and the assurance of efficient and effective transitions.
3. We recommend harmonizing the PI program and MIPS PI category (formerly ACI) to promote the sought after interoperability strategy and workflows between settings of care. Each objective and measure that will interoperate with ambulatory setting of care should be considered. This alignment of objectives and measure does support interoperability and ease the burden on providers.
4. We encourage the measurement requirements to focus not only on effective sharing of health information, but also the effective use of the information by individuals, communities, and providers across the health care continuum.

Specific Comments and Recommendations

#	Proposed Change and Implementation Details	Comments and Recommendations
1.	**Renaming the EHR Incentive Program (Page 1332)** Renaming the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability (PI) Programs. This applies to ▪ Medicare fee-for-service ▪ Medicare Advantage ▪ Medicaid	**Comment** "Promoting" interoperability is a passive term. We suggest "advancing" or "achieving". The new title is based on the assumption that providers have achieved optimal/effective/meaningful use of EHRs. This assumption is incorrect. All providers and states still struggle to achieve effective use. The opioid epidemic is one of many example of how effective use of EHRs has not been achieved. **Recommendation** We recommend a name more reflective of the current status and need such as

		"Advancing effective use and interoperability".
2.	**Certification Requirements Beginning in 2019 (Pages 1332-1338)** Continuing CEHRT flexibility in 2018 allowing health care providers in EHR Incentive Programs to use either the 2014 or 2015 Edition or a combination of both Editions in 2018. (Page 1333)	**Comment** Agree with this proposed continuation of flexibility to use either 2014 or 2015 Edition in 2018.
3.	**Certification Requirements Beginning in 2019 (Pages 1332-1338)** Beginning with EHR reporting period in CY 2019, the 2015 Edition of CEHRT is required. (Page 1333)	**Comment** There is support for moving to the 2015 Edition but concern about the EHR vendor backlog and the 18+ months to implement EHR updates and versions. **Recommendation** We recommend explicitly including a hardship option for providers in que for the 2015 Edition for 2019 and 2020.
4.	**Proposed Revisions to EHR Reporting in 2019 and 2020 (1338-1341)** We are proposing the EHR reporting periods in 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency would be a minimum of any continuous 90-day period within each of the calendar years 2019 and 2020. (Page 1340) This would mean that EPs that attest to a State for the State's Medicaid Promoting Interoperability Program and eligible hospitals and CAHs attesting to CMS or the State's Medicaid Promoting Interoperability Program would attest to meaningful use of CEHRT for an EHR reporting period of a minimum of any continuous 90-day period from January 1, 2019 through December 31, 2019 and from January 1, 2020 through December 31, 2020, respectively. (Page 1341)	**Comment** We support this as a strategy as it will help address the backlog of 2015 Edition by allowing providers to select the measurement period that best fits their situation and need.

	The applicable incentive payment year and payment adjustment years for the EHR reporting periods in 2019 and 2020, as well as the deadlines for attestation and other related program requirements, would remain the same as established in prior rulemaking. We are proposing corresponding changes to the definition of "EHR reporting period" and "EHR reporting period for a payment adjustment year" at 42 CFR 495.4. (Page 1341)	
5.	**Proposed Scoring Methodology <u>for Eligible Hospitals and CAHs</u> Attesting Under the Medicare Promoting Interoperability Program (Page 1341-1364)** We are proposing a new performance-based scoring methodology with fewer measures, and moving away from the threshold-based methodology that we currently use. We are proposing the performance-based scoring methodology would apply to <u>eligible hospitals and CAHs that submit an attestation to CMS under the Medicare Promoting Interoperability Program</u> beginning with the EHR reporting period in CY 2019. This would include "Medicare-only" eligible hospitals and CAHs (those that are eligible for an incentive payment under Medicare for meaningful use of CEHRT and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use) as well as "dual-eligible" eligible hospitals and CAHs (those that are eligible for an incentive payment under Medicare for meaningful use of CEHRT and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use, and are also eligible to earn a Medicaid incentive payment for meaningful use). (Page 1344 -1345)	No Comment.

6.	**Proposed Scoring Methodology for Eligible Hospitals and CAHs Attesting Under the Medicare Promoting Interoperability Program (Page 1341-1364)** We are not proposing to apply the performance-based scoring methodology to "Medicaid-only" eligible hospitals (those that are only eligible to earn a Medicaid incentive payment for meaningful use of CEHRT, and are not eligible for an incentive payment under Medicare for meaningful use and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use) that submit an attestation to their State Medicaid agency for the Medicaid Promoting Interoperability Program. Instead, as discussed in section VIII.D.7. of the preamble of this proposed rule, we are proposing to give States the option to adopt the performance-based scoring methodology along with the measure proposals discussed in section VIII.D.6. of the preamble of this proposed rule for their Medicaid Promoting Interoperability Programs through their State Medicaid HIT Plans.	We support giving States the option to adopt the performance-based scoring methodology.
7.	**Proposed Performance-Based Scoring Methodology (1347-1364)** Proposed Approach Overview (1347-1349) We are proposing a new scoring methodology to include a combination of new measures, as well as the existing Stage 3 measures of the EHR Incentive Program, broken into a smaller set of four objectives and scored based on performance and participation. The smaller set of objectives would include: ▪ e-Prescribing ▪ Health Information Exchange ▪ Provider to Patient Exchange ▪ Public Health and Clinical Data Exchange	**Comments** This scoring measure does align with MIPS and the methodology make sense.

	We are seeking public comment on the proposed requirement to report on all required measures, or whether reporting on a smaller subset of optional measures would be appropriate. (1358) We are seeking public comment on whether these measures are weighted appropriately, or whether a different weighting distribution, such as equal distribution across all measures would be better suited to this program and this proposed scoring methodology. (1361) We are also seeking public comment on other scoring methodologies such as the alternative we considered and described earlier in this section. (1361)	
8.	**Proposed Performance-Based Scoring Methodology (1347-1364)** We are seeking public comment on whether the Security Risk Analysis measure should remain part of the program as an attestation with no associated score, or whether there should be points associated with this measure (1356).	**Comment** The risk assessment is important but the action taken in response to the findings is very important. To truly see change, there needs to be focus on mitigation/addressing gaps and findings **Recommendation** We recommend looking at measures, tools, and resources focused on the outcomes/actions in response to the risk analysis.
9.	**Proposed Performance-Based Scoring Methodology (1347-1364)** Proposed Performance-based Scoring Methodology for EHR Reporting Periods in 2019 (Table on pages 1359-1360)	No Comment.
10.	**Proposed Performance-Based Scoring Methodology (1347-1364)** Proposed Performance-based Scoring Methodology for EHR Reporting Periods in 2020 (Table on page 1360)	No Comment.

11.	**Proposed Performance-Based Scoring Methodology (1347-1364)** Alternative Approach (1349-1350) We also considered an alternative approach in which scoring would occur at the objective level, instead of the individual measure level, and eligible hospitals or CAHs would be required to report on only one measure from each objective to earn a score for that objective. Under this scoring methodology, instead of six required measures, the eligible hospital or CAH's total Promoting Interoperability score would be based on only four measures, one measure from each objective. Each objective would be weighted similarly to how the objectives are weighted in our proposed methodology, and bonus points would be awarded for reporting any additional measures beyond the required four. We are seeking public comment on this alternative approach, and whether additional flexibilities should be considered, such as allowing eligible hospitals and CAHs to select which measures to report on within an objective and how those objectives should be weighted, as well as whether additional scoring approaches or methodologies should be considered.	No Comment.
12.	**Measure Proposals for the e-Prescribing Objectives (1371-1388)** Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP) (1374-1380) Proposed Measure Description: For at least one Schedule II opioid electronically prescribed using CEHRT during the EHR reporting period, the eligible hospital or CAH uses data from CEHRT to conduct a query of a	**Comment** There are many concerns about the use of the PDMP and vendor monopoly due to proprietary interface. Some of these issues, as well as other ways to use e-health to prevent and respond to the opioid epidemic, were addressed in the Minnesota e-Health Advisory Committee's recommendation to Minnesota's Governor Mark Dayton.

	Prescription Drug Monitoring Program (PDMP) for prescription drug history is conducted, except where prohibited and in accordance with applicable law. We are proposing that the query of the PDMP for prescription drug history must be conducted prior to the electronic transmission of the Schedule II opioid prescription. Eligible hospitals and CAHs would have flexibility to query the PDMP using CEHRT in any manner allowed under their State law. We are proposing to include in this measure all permissible prescriptions and dispensing of Schedule II opioids regardless of the amount prescribed during an encounter in order for eligible hospitals and CAHs to identify multiple provider episodes (physician shopping), prescriptions of dangerous combinations of drugs, prescribing rates and controlled substances prescribed in high quantities. However, we are proposing that multiple Schedule II opioid prescriptions prescribed on the same date by the same eligible hospital or CAH would not require multiple queries of the PDMP. We have also considered that in most cases, only one instance of querying the PDMP may be necessary or appropriate for each hospital stay, and querying the PDMP on each day a medication is prescribed may be burdensome for providers. We are requesting comment on whether we should further refine the measure to limit queries of the PDMP to once during the stay regardless of whether multiple eligible medications are prescribed during this time. **Denominator:** Number of Schedule II opioids electronically prescribed using CEHRT by the eligible hospital or CAH during the EHR reporting period.	These recommendations are attached in Appendix A and should be reviewed. **Recommendation** We recommend that CMS clarify as soon as possible if PDMP could be a public health registry as now it is a measure under e-prescribing. We recommend that CMS and partners identify and implement strategies to assure affordable, effective and seamless use of PDMPs by prescribers and dispensers from the electronic health record, integrating into health information exchange services with full implementation of clinical guidelines and clinical decision support and access to other states' PDMPs information. We recommend CMS and partners work to assure stakeholder input and oversight, representative governance, regulatory authority, and funding of the PDMPs to support alignment with state and federal requirements and standards, to improve data quality and usability, to support patient consent and privacy, and to meet workforce-training needs. We recommend CMS and federal partners work to prevent ongoing monopoly through a proprietary interface by at least requiring the use of NCPDP 2017 and other measures to create vendor competition. We recommend CMS and partners work to ensure that state and federal agencies, tribal governments, academia, local public health, payers, and other partners are able to appropriately access and analyze PDMP information for improved prevention, response, and care while safeguarding patient privacy. Transparent processes

	Numerator: The number of Schedule II opioid prescriptions in the denominator for which data from CEHRT is used to conduct a query of a PDMP for prescription drug history except where prohibited and in accordance with applicable law. **Exclusion:** Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions for controlled substances and is not located within 10 miles of any pharmacy that accepts electronic prescriptions for controlled substances at the start of their EHR reporting period. We are proposing that the exclusion criteria would be limited to prescriptions of controlled substances as the measure action is specific to prescriptions of Schedule II opioids only and does not include any other types of electronic prescriptions. We are seeking public comment on the challenges associated with querying the PDMP with and without CEHRT integration and whether this proposed measure should require certain standards, methods or functionalities to minimize burden. In including EPCS as a component of the measure we are proposing, we acknowledge and are seeking input on perceived and real technological barriers as part of its effective implementation including but not limited to input on two-factor authentication and on the effective and appropriate uses of technology, including the use of telehealth modalities to support established patient provider relationships subsequent to in-person visit(s) and for prescribing purposes. We also are requesting comment on limiting the exclusion criteria to electronic prescription for controlled substances and whether there are circumstances which may justify any additional exclusions for the Query	and principles should developed with input from stakeholders to guide access to the PDMP data. Potential data uses should include, but are not limited to: 1. Identify geographic areas and populations showing indicators of misuse and abuse to better target resources for prevention, response, and coordinated care, treatment, and services. 2. Ensure more timely and accurate responses to misuse and overdoses by leveraging other data sources such as overdose, toxicology, and drug seizure reports; medical examiner/coroner data; payer claims; poison control reports; and birth and death records. 3. Support the development and use of advanced clinical decision support and clinical guidelines to flag suspicious behavior and/or patterns and identify individuals at risk for opioid misuse at the point of care and beyond. 4. Identify critical needs for training and best practices for prescribers, dispensers and other providers such as emergency medical services and local public health. Based on the State's Health Information Exchange strategy, the measure for querying the PDMP may be met by accessing the HIO for prescription history and refills for all medications including EPCS, as well as other pertinent information consolidated from multiple providers for an individual.

	of PDMP measure and what those circumstances might be.	
13.	We note that the NCPDP SCRIPT 2017071 standard for e-prescribing is now available and can help to support PDMP and EHR integration. We are seeking public comment especially from health care providers and health IT developers on whether they believe use of this standard can support eligible hospitals and CAHs seeking to report on this measure, and whether HHS should encourage use of this standard through separate rulemaking.	**Comment** There are many concerns about the use of the PDMP and vendor monopoly in this field. These issues, as well as other ways to use e-health to prevent and respond to the opioid epidemic, were addressed in the Minnesota e-Health Advisory Committee's recommendation to Minnesota's Governor Mark Dayton. These recommendation are attached in Appendix A and should be reviewed. **Recommendation** We recommend CMS and federal partners work to prevent ongoing monopoly through a proprietary interface by requiring use of NCPDP 2017.
14.	**Measure Proposals for the e-Prescribing Objectives (1371-1388)** <u>Proposed Measure: Verify Opioid Treatment Agreement (1380-1388)</u> The intent of this measure is for eligible hospitals and CAHs to identify whether there is an existing opioid treatment agreement when they electronically prescribe a Schedule II opioid using CEHRT if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days. **Proposed Measure Description:** For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the eligible hospital or CAH using CEHRT during the EHR reporting period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a 6-month look-back period, the eligible hospital or CAH seeks to identify the	**Comments** This is a very difficult, multi-step process that has conflicting data on its effectiveness. There may be technical solutions to support this but these are years away. **Recommendation** We recommend this measure not be included and instead allow providers to focus on implementing EPCS, understanding and using dosing/weaning recommendations , and expanding the use of telemedicine for those misusing opioids. We also recommend reviewing the Minnesota e-Health Advisory Committee's recommendation on using e-health to prevent and respond to

	existence of a signed opioid treatment agreement and incorporates it into CEHRT. **Denominator**: Number of unique patients for whom a Schedule II opioid was electronically prescribed by the eligible hospital or CAH using CEHRT during the EHR reporting period and the total duration of Schedule II opioid prescriptions is at least 30 cumulative days as identified in the patient's medication history request and response transactions during a 6-month look-back period. **Numerator:** The number of unique patients in the denominator for whom the eligible hospital or CAH seeks to identify a signed opioid treatment agreement and, if identified, incorporates the agreement in CEHRT. **Exclusion:** Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions for controlled substances and is not located within 10 miles of any pharmacy that accepts electronic prescriptions for controlled substances at the start of their EHR reporting period. We are proposing that the exclusion criteria would be limited to prescriptions of controlled substances as the measure action is specific to electronic prescriptions of Schedule II opioids only and does not include any other types of electronic prescriptions. We are also proposing that, in order to meet this measure, an eligible hospital or CAH must use the capabilities and standards as defined for CEHRT at 45 CFR 170.315(b)(3), 170.315(a)(10) and 170.205(b)(2). We are requesting comment on the challenges this proposed measure may create for health care providers, how those challenges might be mitigated, and whether this measure should be included as part of the Promoting Interoperability Program.	opioid misuse and overdose (Appendix A).

	We are seeking public comment on the challenges and concerns associated with opioid treatment agreements and how they could impact the feasibility of the proposal. We are seeking public comment on other similar pathways to facilitate the identification and exchange of treatment agreements and opioid abuse treatment planning. For this measure, we are seeking public comment on what characteristics should be included in an opioid treatment agreement and incorporated into CEHRT, such as clinical data, information about the patient's care team, and patient goals and objectives, as well as which functionalities could be utilized to accomplish the incorporation of this information. We are also seeking public comment on methods or processes for incorporation of the treatment agreement into CEHRT, including which functionalities could be utilized to accomplish this. We are seeking public comment on whether there are specific data elements that are currently standardized that should be incorporated via reconciliation and if the "patient health data capture" functionality could be used to incorporate a treatment plan that is not a structured document with structured data elements. We are requesting public comment on limiting the exclusion criteria to electronic prescriptions for controlled substances and whether there are circumstances which may require an additional exclusion for the Verify Opioid Treatment Agreement measure and what those circumstances might be.	
15.	**Measure Proposals for the e-Prescribing Objective (1371-1388)** eRx Prescribing Measure	**Comment** There needs to be clarity on the e-prescribing measure to assure providers

		understand what exactly is being measured such as non-controlled vs all prescriptions.
16.	**Measure Proposals for the e-Prescribing Objective (1371-1388)** E-Prescribing of Controlled Substances (Page 1387) We are requesting comment on whether we should explore adoption of a measure focused only on the number of Schedule II opioids prescribed and the successful use of EPCS for permissible prescriptions electronically prescribed. We are seeking public comment about the feasibility of such a measure, and whether stakeholders believe this would help to encourage broader adoption of EPCS.	**Comment** Only measuring opioids for this measure seems nearsighted. It is better to focus on EPCS than the opioid treatment agreements. **Recommendation** We support a measure for e-prescribing of all controlled substances going into effect by 2020 or later. We recommend the federal government provide resources for prescribers to implement EPCS AND clinical decision support to improve/benefit all prescribing practices.
17.	**Measure Proposals for Health Information Exchange (HIE) Objective (1388-1401)** Proposed Modifications to Send a Summary of Care Measure (1390-1393) We are proposing to change the name of the Send a Summary of Care measure to Support Electronic Referral Loops by Sending Health Information. We are proposing to change the measure description only to remove the previously defined threshold from Stage 3, in alignment with our proposed implementation of a performance-based scoring system, to require that the eligible hospital or CAH create a summary of care record using CEHRT and electronically exchange the summary of care record for at least one transition of care or referral. Support Electronic Referral Loops by Sending Health Information: For at least one transition of care or referral, the eligible	**Comment** Beginning on page 1388, it was proposed to focus the measures on interoperability through provider to provider exchange to reduce burden. However, we would caution that setting up point to point exchange may actually add burden and suggest measures for interoperability should support the State's HIE strategy. In 2016, Minnesota legislatively directed a statewide HIE Study to assess the State's legal, financial and regulatory framework for HIE. Appendix B is a summary fact sheet of this study, which includes input from many stakeholders. **Recommendation** We recommend CMS and federal partners take action to achieve interoperability between all providers in the care continuum, and review the full 2018 Minnesota HIE Study report

	hospital or CAH that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.	(http://www.health.state.mn.us/e-health/hie/study/hie-study-report-2018.pdf) or fact sheet in Appendix B. This recommendation would be enhanced if (2) included the option of electronically exchanging the summary of care records through an HIO.
18.	**Measure Proposals for Health Information Exchange (HIE) Objective (1388-1401)** Proposed Removal of the Request/Accept Summary of Care Measure (1393-1395) We are proposing to remove the Request/ Accept Summary of Care measure at § 495.24(c)(7)(ii)(B) under the proposed § 495.24(e)(6) based on our analysis of the existing measure and in response to stakeholder input.	**Comment** We support the removal of this measure, and the next (19) to combine the two into the measure for receiving and incorporating health information (20).
19.	**Measure Proposals for Health Information Exchange (HIE) Objective (1388-1401)** Proposed Removal of the Clinical Information Reconciliation Measure (1395-1396) We are proposing to remove the Clinical Information Reconciliation measure at § 495.24(c)(7)(ii)(C) from the new measures at proposed § 495.24(e)(6) to reduce redundancy, complexity, and provider burden.	**Comment** We support the removal of this measure, to combine the two into the measure for receiving and incorporating health information
20.	**Measure Proposals for Health Information Exchange (HIE) Objective (1388-1401)** Proposed New HIE Measure: Support Electronic Referral Loops by Receiving and Incorporating Health Information (1397-1401) We are proposing to add the following new measure for inclusion in the Health Information Exchange objective at § 495.24(e)(6)(ii)(B): Support Electronic Referral Loops by Receiving and Incorporating Health Information. This	**Comments** A suggested option for this measure (receiving), and that of measure of 17 (sending) health information be through the use of an HIO. Providers who do not have a 2015 CEHRT, or any EHR, may access referral information and create, send a response to close the loop through an HIO provider portal. This might also help close the gap between the 'haves and have-nots', while still promoting interoperability.

	measure would build upon and replace the existing Request/Accept Summary of Care and Clinical Information Reconciliation measures. Description: For at least one electronic summary of care record received for patient encounters during the EHR reporting period for which an eligible hospital or CAH was the receiving party of a transition of care or referral, or for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient, the eligible hospital or CAH conducts clinical information reconciliation for medication, mediation allergy, and current problem list. Denominator*:* Number of electronic summary of care records received using CEHRT for patient encounters during the EHR reporting period for which an eligible hospital or CAH was the receiving party of a transition of care or referral, and for patient encounters during the EHR reporting period in which the eligible hospital or CAH has never before encountered the patient. Numerator*:* The number of electronic summary of care records in the denominator for which clinical information reconciliation is completed using CEHRT for the following three clinical information sets: ▪ Medication – Review of the patient's medication, including the name, dosage, frequency, and route of each medication; ▪ Medication allergy – Review of the patient's known medication allergies; and ▪ Current Problem List – Review of the patient's current and active diagnoses. We also are proposing that, in order to meet this measure, an eligible hospital or CAH	In addition, it was mentioned by stakeholders that many providers use Direct Secure Messaging, and that incorporating the PDF information would be difficult. Other transport methods might be an option. Regarding the Medication Reconciliation List - this is currently on the (3rd level) Emerging Status Data Class of the Core Data Elements (USCDI) table. If it is truly a priority to have information on whether or not the latest medication list was reconciled, which care coordinators and users of an HIO might prefer, then suggest moving it to the 1st level data class table. **Recommendation** We recommend considering HIO service options for providers without 2015 CEHRT EHRs to meet this measure of interoperability, and using related Denominator/Numerator based on metrics from the HIO. We also recommend that if Direct Secure Messaging is the preferred transport method, that HIE services for transforming the PDF into a clinical message be required to incorporate the health information. Alternative interoperability transport methods could also be encouraged.

	must use the capabilities and standards as defined for CEHRT at 45 CFR 170.315(g)(1) and (g)(2). Finally, we are proposing to apply our existing policy for cases in which the eligible hospital or CAH determines no update or modification is necessary within the patient record based on the electronic clinical information received, and the eligible hospital or CAH may count the reconciliation in the numerator without completing a redundant or duplicate update to the record. We welcome public comment on methods by which this specific action could potentially be electronically measured by the provider's health IT system – such as incrementing on electronic signature or approval by an authorized provider – to mitigate the risk of burden associated with manual tracking of the action. We are seeking public comment on methods and approaches to quantify the reduction in burden for eligible hospitals and CAHs implementing streamlined workflows for this proposed measure. We also are seeking public comment on the impact these proposals may have for health IT developers in updating, testing, and implementing new measure calculations related to these proposed changes. Specifically, we are seeking public comment on whether ONC should require developers to recertify their EHR technology as a result of the changes proposed, or whether they should be able to make the changes and engage in testing without recertification. Finally, we are seeking public comment on whether this proposed new measure that combines the Request/Accept Summary of Care and Clinical Information Reconciliation measures should be adopted, or whether either or both of the existing Request/Accept	

	Summary of Care and Clinical Information Reconciliation measures should be retained in lieu of this proposed new measure.	
21.	**Measure Proposals for the Provider to Patient Exchange Objective (1401-1409)** <u>Proposed Modifications to Provide Patient Access Measure (1403-1404)</u> We are proposing to change the name of the Provide Patient Access measure at 42 CFR 495.24(c)(5)(ii)(A) to Provide Patients Electronic Access to Their Health Information. We are proposing to change the measure description only to remove the previously established threshold from Stage 3, in alignment with our proposed implementation of a performance-based scoring methodology, to require that the eligible hospital or CAH provide timely access for viewing, downloading or transmitting their health information for at least one unique patient discharged using any application of the patient's choice. Proposed name and measure description: Provide Patients Electronic Access to Their Health Information: For at least one unique patient discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23): ▪ The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and ▪ The eligible hospital or CAH ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the eligible hospital or CAH's CEHRT.	**Comments** There are a lot of questions and concerns around this measure including: making providers vulnerable, access to entire record, need for trust and technical agreements, and lack of streamlined process to accomplish this activity. There are a lot of legal aspects to be considered and addressed to assure alignment. **Recommendation** We recommend reviewing this measure to identify the value to providers and patients as well as if the process is too burdensome to providers.

22.	**Measure Proposals for the Provider to Patient Exchange Objective (1401-1409)** <u>Proposed Removal of the Patient-Specific Education Measure (1405-1406)</u> We are proposing to remove the Patient-Specific Education measure at § 495.24(c)(5)(ii)(B) at proposed § 495.24(e)(7) as it has proven burdensome to eligible hospitals and CAHs in ways that were unintended and detract from health care providers' progress on current program priorities.	No Comment.
23.	**Measure Proposals for the Provider to Patient Exchange Objective (1401-1409)** <u>Proposed Removal of the Secure Messaging Measure (1406-1408)</u> We are proposing to remove the Secure Messaging measure at § 495.24(c)(6)(ii)(B) at proposed § 495.24(e)(7) as it has proven burdensome to eligible hospitals and CAHs in ways that were unintended and detract from health care providers' progress on current program priorities.	**Comment** The use of secure message between patients and hospitals has been difficult. This has been more successful with clinics and EP.
24.	**Measure Proposals for the Provider to Patient Exchange Objective (1401-1409)** <u>Proposed Removal of the View, Download or Transmit Measure (1408-1409)</u> We are proposing to remove the View, Download or Transmit measure at § 495.24(c)(6)(ii)(A) at proposed § 495.24(e)(7) as it has proven burdensome to eligible hospitals and CAHs in ways that were unintended and detract from eligible hospitals and CAHs progress on current program priorities.	No Comment.
25.	<u>Proposed Modifications to the Public Health and Clinical Data Registry Reporting Objective and Measures (1409-1413)</u>	**Comment** The proposed changes would undermine the work done by states and providers to collect, use, and share

	We are proposing to change the name of the objective to Public Health and Clinical Data Exchange. We are proposing that eligible hospitals and CAHs would be required to attest to the Syndromic Surveillance Reporting measure and at least one additional measure from the following options: ▪ Immunization Registry Reporting ▪ Clinical Data Registry Reporting ▪ Electronic Case Reporting ▪ Public Health Registry Reporting ▪ Electronic Reportable Laboratory Result Reporting We intend to propose in future rulemaking to remove the Public Health and Clinical Data Exchange objective and measures no later than CY 2022. We are seeking public comment on whether hospitals will continue to share such data with public health entities once the Public Health and Clinical Data Exchange objective and measures are removed, as well as other policy levers outside of the Promoting Interoperability Program that could be adopted for continued reporting to public health and clinical data registries, if necessary. We are seeking public comment on the role that each of the public health and clinical data registries should have in the future of the Promoting Interoperability Programs and whether the submission of this data should still be required when the incentive payments for meaningful use of CEHRT will end in 2021. Lastly, we are seeking public comment on whether the Promoting Interoperability Programs are the best means for promoting the sharing of clinical data with public health entities.	electronic public health information. The new measures do not support comprehensive, bi-directional public health reporting nor build off of previous investments. Comprehensive, bi-directional public health supports the health and wellness of the entire country. In addition, public health agencies will continue to ask e-public health reporting. Without national consistency as supported by having required public health reporting, the ability to prevent and respond to epidemics will decrease while becoming less effective and efficient. Finally, Minnesota and many states do not support nor have plans to support syndromic surveillance. This means populations living in these states will receive less benefit from timely, accurate public health reporting since providers will only be using one public health registry and taking an exemption on syndromic surveillance. **Recommendation** We recommend providers be able to choose which two or three public health registries from the list they will report on. Syndromic surveillance should not be a required registry. If one registry must be required, it should be immunization. Immunization registries have greater value to both public health and providers. We recommend that CMS clarify as soon as possible if PDMP could be a public health registry as now it is a measure under e-prescribing. We recommend CMS and partners identify additional strategies and resources to create interoperability (bi-directionality) between providers and public health to improve provider and

		patient's ability to make well-informed decisions. We do not support the removal of the public health measures in 2022. Public health will still ask for electronic reporting. Public health cannot afford to continue to collect information in many formats.
26.	**Potential New Measures for HIE Objective: Health Information Exchange Across the Care Continuum (1413-1416)** We are working to introduce additional flexibility to allow providers a wider range of options in selecting measures that are most appropriate to their setting, patient population, and clinical practice improvement goals. For this reason, we are seeking public comment on a potential concept for two additional measure options for the Health Information Exchange objective for eligible hospitals and CAHs. **New Measure Description for Support Electronic Referral Loops by Sending Health Information Across the Care Continuum:** For at least one transition of care or referral to a provider of care other than an eligible hospital or CAH, the eligible hospital or CAH creates a summary of care record using CEHRT; and electronically exchanges the summary of care record. **New Measure Denominator:** Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) was the transitioning or referring provider to a provider of care other than an eligible hospital or CAH. **New Measure Numerator:** The number of transitions of care and referrals in the denominator where a summary of care	**Comment** The summary of care record has too much information and not the right information. **Recommendation** We recommend more work to address the amount and type of information exchanged for these potential new measures. We also recommend identifying strategies to engage all providers across the care continuum including behavioral health, dental health, local public health, long-term and post-acute care, and social services. Finally, we encourage the option for providers to utilize the consolidation services of an HIO or other entity to obtain more pertinent and useful summary of care information for their patients, and incorporate the information into their EHR and/or workflow. This recommendation would include that the provider also contribute information to that consolidated and longitudinal patient record for future provider visits.

	record was created and exchanged electronically using CEHRT. **New Measure Description for Support Electronic Referral Loops By Receiving and Incorporating Health Information Across the Care Continuum:** For at least one electronic summary of care record received by an eligible hospital or CAH from a transition of care or referral from a provider of care other than an eligible hospital or CAH, the eligible hospital or CAH conducts clinical information reconciliation for medications, mediation allergies, and problem list. **New Measure Denominator:** The number of electronic summary of care records received for a patient encounter during the EHR reporting period for which an eligible hospital or CAH was the recipient of a transition of care or referral from a provider of care other than an eligible hospital or CAH. **New Measure Numerator:** The number of electronic summary of care records in the denominator for which clinical information reconciliation was completed using CEHRT for the following three clinical information sets: ▪ Medication--Review of the patient's medication, including the name, dosage, frequency, and route of each medication ▪ Medication allergy--Review of the patient's known medication allergies ▪ Current Problem List--Review of the patient's current and active diagnoses. We are seeking public comment on whether these two measures should be combined into one measure so that an eligible hospital or CAH that is engaged in exchanging health information across the care continuum may include any such exchange in a single measure.	

	We are seeking public comment on whether the denominators should be combined to a single measure including both transitions of care from a hospital and transitions of care to a hospital. We also are seeking public comment on whether the numerators should be combined to a single measure including both the sending and receiving of electronic patient health information. We are seeking public comment on whether the potential new measures should be considered for inclusion in a future program year or whether stakeholders believe there is sufficient readiness and interest in these measures to adopt them as early as 2019. For the purposes of focusing the denominator, we are seeking public comment regarding whether the potential new measures should be limited to transitions of care and referrals specific to long-term and post-acute care, skilled nursing care, and behavioral health care settings. We also are seeking public comment on whether additional settings of care should be considered for inclusion in the denominators and if a provider should be allowed to limit the denominators to a specific type of care setting based on their organizational needs, clinical improvement goals, or participation in an alternative payment model. Finally, we are seeking public comment on the impact the potential new measures may have for health IT developers to develop, test, and implement a new measure calculation for a future program year.	
27.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** We are seeking public comment on whether participation in the Trusted Exchange	**Comment** This is a good future option but there are numerous details to be figured out to make this a useful and measureable

	Framework and Common Agreement (TEFCA) should be considered a health IT activity that could count for credit within the Health Information Exchange objective in lieu of reporting on measures for this objective.	measure. Also, while we support the approach to create a nationwide framework with TEFCA, there are many areas where the proposed TEFCA rules do not meet the needs of public health. For example, in not including a push use case, TEFCA as written leaves out the primary method for immunization submission, which will keep the majority of immunization reporting outside of TEFCA's proposed activities. **Recommendation** We recommend TEFCA be implemented before discussing measures. This will allow for development of useable and measureable measures at a later date. If participation in TEFCA is considered an incentivized health IT activity, we recommend that the scope of TEFCA be expanded to include the needs of public health, while also leveraging the strengths of public health data. Finally, the TEFCA proposed activities seem to focus on query and response only, and this may be helpful to obtain information on a patient with visits across the country. However, the TEFCA activity could be complimentary HIE to local (or State) coordination and consolidation of patient longitudinal information for better use by providers, payers, individuals and communities.
28.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** We also are considering a health IT activity in which eligible hospitals and CAHs could obtain credit if they maintain an open API which allows patients to access their health information through a preferred third party.	**Comment** Flexibility is good but there is a lot of learning in this area for providers. Also, there needs to be more clarify around terms and possible measures in this area. **Recommendation** We recommend CMS, ONC, and partners continue to provide training

		and resources around API and implications for patient access.
29.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** We are considering developing a health IT activity which would allow eligible hospitals and CAHs to obtain credit under the Public Health and Clinical Data Exchange objective for piloting emerging technology standards.	**Comment** This proposed change would undermine the work done by states and providers to collect, use, and share electronic public health information. This does not support comprehensive, bi-directional public health reporting nor build off of previous investments. Comprehensive, bi-directional public health supports the health and wellness of the entire country. In addition, public health agencies will continue to ask e-public health reporting. Without national consistency as supported by having required public health reporting, the ability to prevent and respond to epidemics will decrease while becoming less effective and efficient. Finally, Minnesota and many states do not support nor have plans to support syndromic surveillance. **Recommendation** We do not support this strategy as it undermines public health reporting, public health, and previous investments in e-public health reporting.
30.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** What health IT activities should CMS consider recognizing in lieu of reporting on objectives that would most effectively advance priorities for nationwide interoperability and spur innovation? What principles should CMS employ to identify health IT activities?	**Comment** To advance interoperability, other settings of care such as behavioral health, local public health, long-term and post-acute care, and social services need to receive resources (funding and training) to be interoperable. **Recommendations** We recommendation that CMS, ONC, and federal partners provide resources to the full continuum of care including at least behavioral health, local public

		health, long-term and post-acute care, and social services. This would align with and build off of the SIM funding and activities.
31.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** Do stakeholders believe that introducing health IT activities in lieu of reporting on measures would decrease burden associated with the Promoting Interoperability Programs?	**Comment** States that are more advanced in HIE can get more credit which could create a bigger divide between the haves and have nots.
32.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** If additional measures were added to the program, what measures would be beneficial to add to promote our goals of care coordination and interoperability?	**Comment** A potential measure around alerts may be of value. It is important that all measures focus on value/use and not just numbers.
33.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** How can the Promoting Interoperability Program for eligible hospitals and CAHs further align with the Quality Payment Program (for example, requirements for eligible clinicians under MIPS and Advanced APMs) to reduce burden for health care providers, especially hospital-based MIPS eligible clinicians?	**Comment** Any similarity, uniformity or harmonizing the CMS can create between the QPP/MIPS program and the MU (now Promoting Interoperability) program will greatly reduce administrative overhead and create consistency between the programs. The MIPS program is structured into 4 categories and CMS may wish to consider similar alignment for hospitals under PI. The PI category in MIPS (formerly ACI) is being aligned under the proposed IPPS rule and the specific objectives and measures should be consistent between the two programs. **Recommendation** We recommend that the submission and reporting mechanisms be aligned (MIPS has options that vary by specific category and, ultimately, the results and data are available (and reportable)

		via the QualityNext portal with a CMS EIDM account). Additionally, it would be helpful to do a crosswalk between MIPS and the proposed IPPS 'Promoting Interoperability' program to identify areas of possible increased harmonization and alignment.
34.	**Promoting Interoperability Program Future Direction (Pages 1418-1422)** What other steps can HHS take to further reduce the administrative burden associated with the Promoting Interoperability Program?	**Recommendation** We recommend looking at states and other programs that have had success in tying incentives to or with the payer as well.
35.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** <u>Proposed CQMs for Reporting Periods Beginning with CY 2020 (1423-1426)</u> To align with the Hospital IQR Program, we are proposing to reduce the number of eCQMs in the Medicare and Medicaid Promoting Interoperability Programs eCQM measure set from which eligible hospitals and CAHs report, by proposing to remove eight eCQMs (from the 16 eCQMs currently in the measure set) beginning with the reporting period in CY 2020. The eight eCQMs we are proposing to remove are: ▪ Primary PCI Received Within 90 Minutes of Hospital Arrival ▪ Home Management Plan of Care Document Given to Patient/Caregiver ▪ Median Time from ED Arrival to ED Departure for Admitted ED Patients ▪ Hearing Screening Prior to Hospital Discharge ▪ Elective Delivery	**Comment** There was ambiguity as to if the removal of these measures was "good" or "bad". These eCQMs are still important and relate to significant individual and population health problems such as stroke, early hearing screening, and maternal deaths. **Recommendations** We recommend working with the populations and communities that are directly affected by the health issues to identify if these eCQMs are valuable and what are possible unintended consequences of removal.

	▪ Stroke Education ▪ Assessed for Rehabilitation ▪ Median Time from ED Arrival to ED Departure for Discharged ED Patients We note that the first seven eCQMs on this list are currently included in the Hospital IQR Program, and in section VIII.A.5.(b)(9), we are proposing to remove them from the Hospital IQR Program beginning in CY 2020. We are inviting public comment on our proposal, including the specific measure proposed for removal and the timing of removal from the Medicare and Medicaid Promoting Interoperability Programs.	
36.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** <u>Proposed CQM Reporting Periods and Criteria for the Medicare and Medicaid Promoting Interoperability Programs in CY 2019 (1426-1428)</u> For the reporting period in CY 2019 reporting period, we are proposing the following for CQM submission under the Medicare Promoting Interoperability Program: ▪ Eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program (single program participation)—electronically report CQMs through QualityNet Portal. ▪ Eligible hospital and CAH options for electronic reporting for multiple programs (that is, Promoting Interoperability Program and Hospital IQR Program participation)—electronically report through QualityNet Portal. For CY 2019, we are proposing to continue our policy regarding the electronic submission of CQMs, which requires the use of the most recent version of the CQM	**Recommendation** We recommend aligning with MIPS and assure that the measures and process are harmonized to allow for single mechanisms for reporting.

	electronic specification for each CQM to which the EHR is certified. For the CY 2019 electronic reporting of CQMs, this means eligible hospitals and CAHs are required to use the Spring 2017 version of the CQM electronic specifications. In addition, we are proposing that eligible hospitals or CAHs must have their EHR technology certified to all 16 available CQMs listed in the table above. As discussed in section VIII.D.3. of the preamble of this proposed rule, eligible hospitals and CAHs are required to use 2015 Edition CEHRT for the Medicare and Medicaid Promoting Interoperability Programs in CY 2019. We reiterate that an EHR certified for CQMs under the 2015 Edition certification criteria does not have to be recertified each time it is updated to a more recent version of the CQMs (82 FR 38485). We are requesting public comments on these proposals.	
37.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** <u>Request for Comment (1430-1433)</u> What aspects of the use of eCQMs are most burdensome to hospitals and health IT vendors?	**Comments** There needs to be more clarity on the measures. The "what and how" to measure vary too greatly between providers. This makes the value of the information not worth the burden. There needs to be better ways to report quality measures – less reporting and more pulling.
38.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** <u>Request for Comment (1430-1433)</u> What program and policy changes, such as improved regulatory alignment, would have	No Comment.

	the greatest impact on addressing eCQM burden?	
39.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** Request for Comment (1430-1433) What are the most significant barriers to the availability and use of new CQMs today?	No Comment.
40.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** Request for Comment (1430-1433) What specifically would stakeholders like to see us do to reduce burden and maximize the benefits of eCQMs?	No Comment.
41.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** Request for Comment (1430-1433) How could we encourage hospitals and health IT vendors to engage in improvements to existing eCQMs?	No Comment.
42.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** Request for Comment (1430-1433) How could we encourage hospitals and health IT vendors to engage in testing new eCQMs?	No Comment.
43.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)**	No Comment.

	Request for Comment (1430-1433) Would hospitals and health IT vendors be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would explore less burdensome ways of approaching quality measurement, such as sharing data with third parties that use machine learning and natural language processing to classify quality of care or other approaches?	
44.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** Request for Comment (1430-1433) What ways could we incentivize or reward innovative uses of health IT that could reduce burden for hospitals?	No Comment.
45.	**CQMs for Eligible Hospitals and CAHs Participating in the Medicare and Medicaid Promoting Interoperability Programs (pages 1422-1433)** Request for Comment (1430-1433) What additional resources or tools would hospitals and health IT vendors like to have publicly available to support testing, implementation, and reporting of eCQMs?	No Comment.
46.	**Puerto Rico Hospitals (pages 1433-1441)**	
47.	**Proposed Modifications to the Medicaid Promoting Interoperability Program (Pages 1441-1447)**	

RFI Promoting Interoperability and Electronic Health care Information Exchange

#	Question (pages 1471-1484)	Comments and Recommendations
1.	If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?	**Comment** Until there is enforcement behind the policy to prevent information blocking, this strategy may not be helpful.
2.	Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden?	**Comment** There are a lot of questions and concerns around APIs including making providers vulnerable, access to entire record, need for trust and technical agreements, and lack of streamlined process to accomplish this activity. Also, is this policy being pushed with the hope that legal catches up?
3.	Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?	**Comment** Currently, patients are expected to manage multiple portals. A patient centered data home may be an option for individual/caregiver access to a consolidated and longitudinal health record. Querying for this may also ease the provider burden by not looking through so many documents received through a query and response only format.

#	Question (pages 1471-1484)	Comments and Recommendations
4.	Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?	**Comment** Advancing electronic exchange of health information is important, however it would be helpful to focus beyond the sharing of information to the effective use of the information shared.
5.	What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements?	**Comment** Similar to above comments regarding the use of 2015 CEHRT by 2019, it is suggested to allow exclusions for those providers still in the cue with vendors to implement compliance requirements.
6.	Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?	**Comment** Providers that have not been eligible for EHR Incentive programs are not as ready to implementing some of these requirements.
7.	Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?	**Comment** Yes. As described in the Minnesota HIE Study (http://www.health.state.mn.us/e-health/hie/study/index.html) published in April 2018, exchanging health information for transitions of care is encouraged to improve patient care, reduce costs, and improve quality of care, including patient safety.

#	Question (pages 1471-1484)	Comments and Recommendations
8.	Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?	**Comment** Providers commented on the burden of receiving multiple duplicative information from electronic and faxed sources for the same individual, suggesting the use of faxing be quickly discontinued as electronic exchange begins, or only fax if information is missing rather than sending both formats of information.
9.	Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?	No Comment.
10.	What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?	**Comment** Suggest allowing exceptions for providers who are in the cue with a vendor for implementing the requirements.
11.	Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements?	Yes.
12.	Would extending such exceptions impact the effectiveness of these requirements?	**Comment** Yes. Consider organization exceptions for a limited term basis.

#	Question (pages 1471-1484)	Comments and Recommendations
13.	CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients.	**Comment** More information is needed to understand the nuances of the MyHealthEData. Identifying what specific capabilities would be required for the user would be helpful, so there is a base level of expected services.
14.	We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers.	**Comment** Based on the Minnesota HIE Study, described above, MDH has convened an HIE Task Force to address these barriers and identify an implementation plan for transitions of care, event alerting, and a five year plan for governance, authority and financing. Updates of their work can be found at: http://www.health.state.mn.us/e-health/hie/taskforce/index.html
15.	We would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well. (including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers)	**Comment** As an implementation plan for sharing and using information among all providers is identified, providers not eligible for EHR Incentive Programs, such as LTC, LPH, Behavioral Health, and Social Services, are requesting financial incentives to exchange information with those who are eligible. Although some states have used 90/10 funding for this purpose, providers are also looking for trust that the direction of what and how information is shared will not be changed again in the near future.

Appendix A: Opioids and e-Health Report: A Summary of the 2017 Minnesota e-Health Advisory Committee's Opioids and e-Health Recommendations

Opioids and e-Health Report

A SUMMARY OF THE 2017 MINNESOTA E-HEALTH ADVISORY COMMITTEE'S OPIOIDS AND E-HEALTH RECOMMENDATIONS

Introduction

In response to the opioid epidemic, Governor Dayton requested the Minnesota e-Health Advisory Committee provide a set of recommendations for using e-health to prevent and respond to opioid misuse and overdose. The advisory committee, with input from the Opioids and e-Health Steering Team and Minnesota Department of Health, Office of Health Information Technology (OHIT), developed seven recommendations. The advisory committee believes implementation of the recommendations can have a significant impact on mitigating the opioid epidemic. OHIT developed this report to summarize the approach, recommendations and next steps of the advisory committee's work on opioids and e-health.

Approach

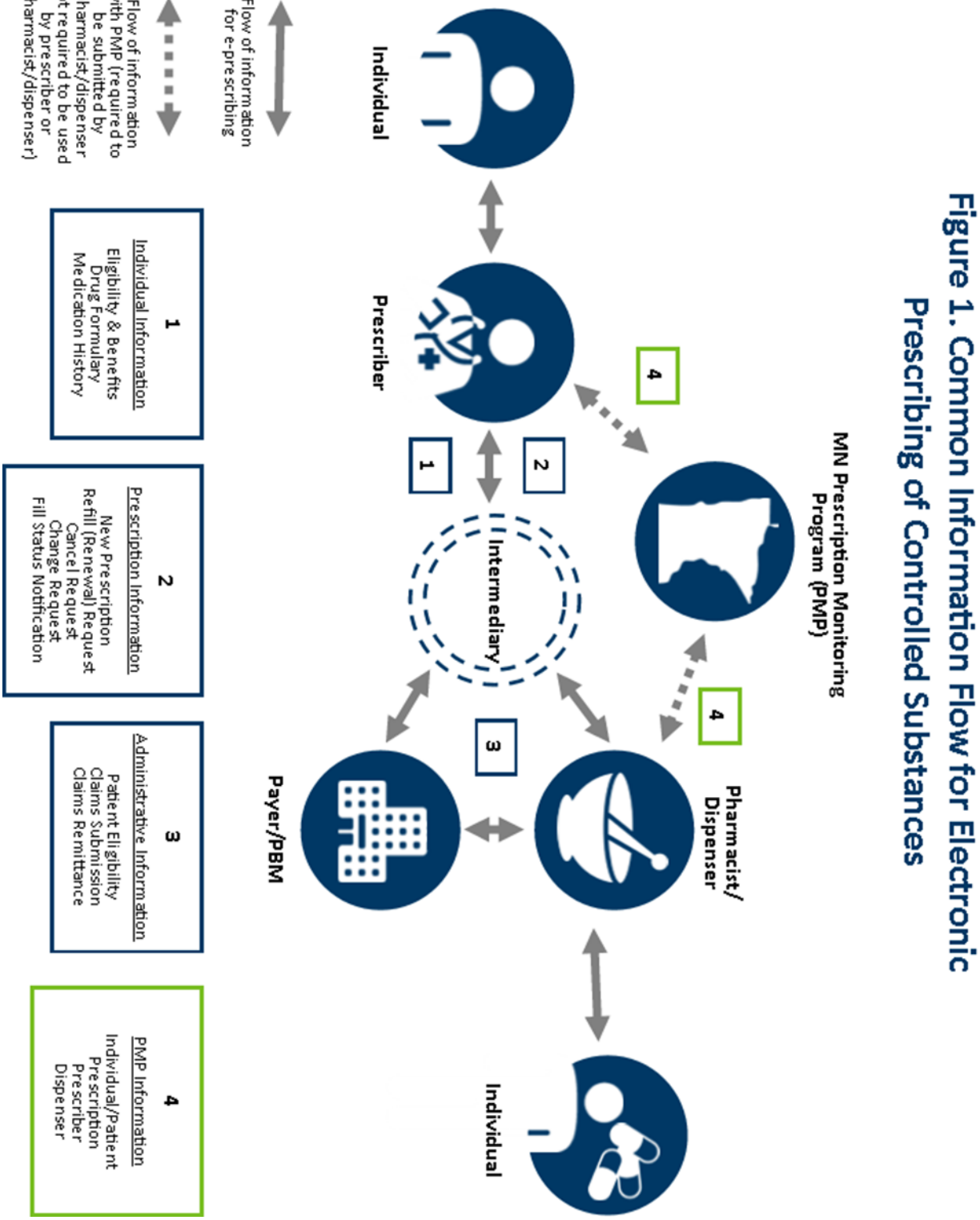
The approach initially focused on the collection, use, and sharing of information necessary for the electronic prescribing of controlled substances (Figure 1) as requested by the advisory committee. With the request from Governor Dayton and input from the community, the scope was broadened to include additional uses of e-health to prevent and respond to opioid misuse and overdose. The following activities were critical to the development of the recommendations and building greater understanding of using e-health to prevent and respond to the opioid epidemic.

Minnesota Environmental Scan

Prescribers, payers, pharmacies and state agencies provided information and perspectives regarding the electronic health care information needed to address the opioid epidemic. The interviews focused on two areas including:

1. Whether and how such information is or could be exchanged via the types of data exchange subject to MN 62J.536 and 62J.495-4982; and
2. Any possible issues or constraints associated with the standard, electronic exchange or use of information needed to address the epidemic and how they might be addressed.

Figure 1. Common Information Flow for Electronic Prescribing of Controlled Substances



Engaging Partners and Collecting Input during the Minnesota e-Health Summit

During the 2017 Minnesota e-Health Summit's, 'Leveraging e-Health to Prevent and Respond to Opioid Misuse and Overdose' session approximately 30 participants from across the care continuum shared feedback on:

- Preferred/recommended data sources;
- How information can best be provided/communicated via standard, electronic health business transactions and electronic health records;
- How electronic health data can be leveraged to help address the opioid epidemic;
- Key obstacles/challenges to providing/communicating the needed information; and
- Changes/solutions needed to address the challenges/obstacles.

Nationwide Scan of Strategies Implemented by States to Address Opioid Epidemic

The scan obtained information about other states' legislative and policy strategies for addressing the epidemic. Key words used in the review included: "opioids," "EPCS" (electronic prescribing of controlled substances), "prescription monitoring program/prescription drug monitoring program," (PMP/PDMP) "medical cannabis," and "individual/patient education."

Opioids and e-Health Steering Team

The Opioids and e-Health Steering Team provided input to the Advisory Committee on recommendations and strategies for using e-health to prevent and respond to opioid misuse and overdose. The participants of the Steering Team included experts in prescribing and dispensing controlled substances, e-prescribing controlled substances, and the Minnesota Prescription Monitoring Program. The Steering Team met twice and shared their perspectives and experiences during numerous advisory committee and public meetings.

Recommendations

The advisory committee believes implementation of the following recommendations can have a significant impact on mitigating the opioid epidemic.

The advisory committee recommends that:

1. By July 2018, the Minnesota Legislature should provide resources to fully implement and ensure compliance with Minnesota Statutes Section 62J.497 including a focus on increasing the rate of e-prescribing of controlled substances from approximately 20 percent (Surescripts 2016 National Progress Report) to over 80 percent by 2020. Implementation of this recommendation should occur with input from the Minnesota e-Health Advisory Committee to:
    a. Provide or ensure statewide education and technical assistance on electronic prescribing (e-prescribing) of controlled substances.

b. Support full-implementation of all e-prescribing related transactions in the nationally recognized National Council for Prescription Drug Programs Standards (NCPDP), including electronic prior authorization and Formulary and Benefits.
c. Provide grants to increase the rate of e-prescribing of controlled substances. Grantees include, but are not limited to, prescribers that serve rural or underserved populations; prescribers that have small, independent practices; and other providers needing support such as dentists.
d. Support the use of evidence-based clinical guidelines and clinical decision support.
e. Monitor the status of e-prescribing, specifically for controlled substances, and assess the barriers to e-prescribing of controlled substances.
f. Develop and implement policy options including rulemaking and enforcement for non-compliance of e-prescribing as needed, if goals are not met.

2. By January 2019, the Minnesota Board of Pharmacy, with input from the Minnesota e-Health Advisory Committee, health and health care provider associations, and other stakeholders, should develop requirements and an implementation plan to improve the Prescription Monitoring Program (PMP). The requirements and implementation plan should include use cases and policies for the required use of the PMP. The implementation plan should:
    a. Address affordable, effective and seamless use of the PMP by prescribers and dispensers through the EHR, other HIT, and integration into Minnesota's HIE and include full implementation of clinical guidelines and clinical decision support and access to other states' PMP information.
    b. Improve stakeholder input and oversight, representative governance, regulatory authority, and funding of the PMP to support alignment with state and federal requirements and standards, improve data quality and usability, support patient consent and privacy, and meet workforce-training needs.

    The Governor and Legislature should appropriate funds for the development and implementation of the requirements and implementation plan to improve the PMP.

3. By July 2018, the Minnesota Legislature should amend Minnesota Statutes, Section 152.126 to expand the permitted uses of Prescription Monitoring Program data. The updated language should ensure that state and federal agencies, tribal governments, academia, local public health, payers, and other partners are able to appropriately access and analyze information for improved prevention, response, and care while safeguarding patient privacy in accordance with state and federal law. Transparent processes and principles developed by the Board of Pharmacy with input from the Minnesota e-Health Advisory Committee and other stakeholders should guide access to

the Prescription Monitoring Program data. Potential data uses should include, but are not limited to:

a. Identify geographic areas and populations showing indicators of misuse and abuse to better target resources for prevention, response, and coordinated care, treatment, and services.
b. Ensure more timely and accurate responses to misuse and overdoses by leveraging other data sources such as overdose, toxicology, and drug seizure reports; medical examiner/coroner data; payer claims; poison control reports; and birth and death records.
c. Support the development and use of advanced clinical decision support and clinical guidelines to flag suspicious behavior and/or patterns and identify individuals at risk for opioid misuse at the point of care and beyond.
d. Identify critical needs for training and best practices for prescribers, dispensers and other providers such as emergency medical services and local public health.

The Governor and Legislature should appropriate funds to support the expanded uses of the Prescription Monitoring Programs data, and develop and implement the transparent processes and principles to guide access to data.

4. State agencies and associations should, by September 2018, review, update, and provide education on e-health and opioids policies and guidelines to ensure dispensers, prescribers, payers, and other providers, including the care team, have appropriate and timely access to health information, can subsequently share information, and understand their scope of action related to the information. Use cases should include, but are not limited to, instances when prescribing and dispensing practices are outside nationally recognized clinical guidelines, such as those published by the Centers for Disease Control and Prevention and the U.S. Food and Drug Administration, and individuals are at-risk for misuse and abuse.

5. The Governor, by July 2018, should ensure access and coverage for all Minnesotans and providers, and provide resources for grants and technical assistance, to expand access to services and care enabled by telehealth, telemedicine and other forms of virtual technology to fill access gaps in opioid tapering and withdrawal, chemical dependency, mental health, and alternative pain treatment and services.

6. The Governor should support state agencies and stakeholders in participating in statewide coordinated HIE services. The support should be consistent with the findings of Minnesota Health Information Exchange Study, which will be submitted to the Legislature in February of 2018, align with input from the Minnesota e-Health Advisory Committee, ensure providers and public health have access to information to support individual and community health services, and support:

a. Alerts for emergency services, urgent care, and other medical visits relating to substance misuse and overdose.
b. Referrals to substance abuse treatment and community services.
c. Access to patient health history including medication lists.

7. The Minnesota Department of Health, by December 2018, should submit to the Governor and the Legislature an update to their informatics profile that assesses the gaps in current information and information systems used to prevent and respond to substance misuse and overdose and identify resources needed to fill those gaps. The Governor and Legislature should appropriate funds to ensure those needs are met.

The advisory committee also recognized that mitigating the opioid epidemic goes beyond e-health. There is a need for better access to and coverage for health services, specifically opioid tapering and withdrawal, chemical dependency, mental health and alternative pain treatment and services. Therefore, they also recommend the Governor work to ensure all Minnesotans have access to the treatment and services needed to achieve health and wellbeing.

Next Steps

The advisory committee and its stakeholders will continue to prioritize work to mitigate the opioid epidemic. In the coming months, it will move forward with the findings of the legislatively mandated study on HIE, which improves the seamless flow of information to prescribers and dispensers. It will continue to monitor and provide input into state and national activities regarding e-prescribing of controlled substances, Prescription Monitoring Program, and related issues.

Appendix B: Health Information Exchange (HIE) Study Fact Sheet (April 2018)

Health Information Exchange (HIE) Study

APRIL 2018

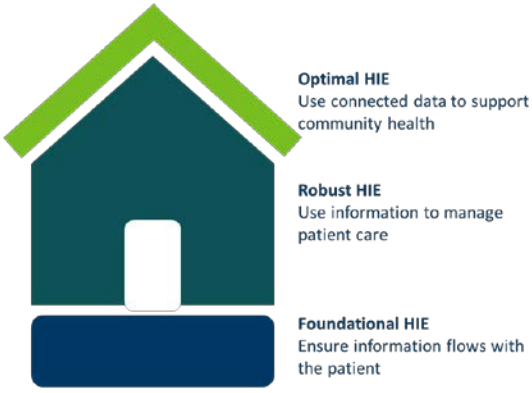
HIE study conducted in response to opportunities to improve health care system in Minnesota

The 2016 Minnesota Legislature directed MDH to assess Minnesota's legal, financial, and regulatory framework for HIE, including the requirements in Minnesota Statutes, Sections 144.291 to 144.298 (the Minnesota Health Records Act), and to recommend modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable. The report is available at: http://www.health.state.mn.us/e-health/hie/study/index.html

Health information exchange presents opportunities to improve individual and community health

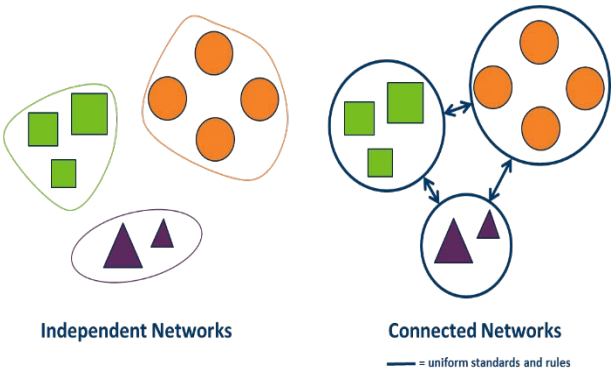
Health Information Exchange (HIE) is the electronic flow of health information between a patient's health care providers. Statewide HIE is critical for providing safe, efficient, effective, coordinated patient care.

Minnesota has made progress on HIE, but it is not yet occurring equitably or robustly across the state. This means that access to health care information for many Minnesotans continues to be inefficient and fragmented when they visit multiple providers or health systems. To have effective HIE, every health organization needs to participate, so that every person's information is more easily available when and where it is needed to better serve them.



This assessment identified three important uses for HIE that can greatly and favorably impact individual and community health. Minnesota needs to establish foundational HIE across all providers in the state to ensure that a person's entire care team is connected for transitions of care, referrals and ongoing coordination with a person's care team.

In Minnesota, quite a lot of HIE is happening, within individual health systems and health information networks. However, many of the networks are not efficiently connected to each other, which means that even foundational HIE is not consistently happening for every patient. Achieving higher levels of HIE will require moving toward a concept of "connected HIE networks," which means that each of these networks has a connection to each other network



and all can exchange clinical information with each other using uniform standards and rules. Any organization that participates with any of those networks is then securely connected to all of the organizations participating in any of the networks.

Recommendations to develop connected networks model

The primary recommendation, based on this study's findings, is to move Minnesota in the direction of a connected networks model that will provide essential HIE services accessible to all stakeholders statewide, and to align with and build upon national initiatives. To achieve this, the assessment, with endorsement from the Minnesota e-Health Advisory Committee, recommends:

1. The Minnesota Legislature should modify the Minnesota Health Records Act to align with HIPAA for disclosure purposes only while maintaining key provisions to ensure patient control of information and to support HIE.
2. MDH should establish a HIE task force of the e-Health Advisory Committee to develop strategic and implementation plans (including rules of the road) for the connected networks model by focusing on actions and policies to: expand exchange of clinical information to support care transitions between organizations that use Epic and those that do not; expand event alerting (for admission, discharge, and transfer) to support effective care coordination; and identify, prioritize and scope needs for ongoing connected networks and HIE services with the goal of optimal HIE.
3. The MN Legislature should act on the recommendations of the e-Health Initiative's HIE task force, which are expected to include: updating Minnesota's Health Information Exchange Oversight law to support the coordinated networks concept; and appropriating funds to help providers connect to HIE services and develop ongoing coordinated HIE services.