EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

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December 20, 2023

Micky Tripathi, Ph.D., M.P.P.
Office of the National Coordinator for Health Information Technology (ONC)
U.S. Department of Health and Human Services
330 C St SW, Floor 7
Washington, DC 20201

RE: 21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking

Dear Dr. Tripathi,

On behalf of the 29 member companies of the HIMSS Electronic Health Record (EHR) Association, we are pleased to provide input on the proposed rule to establish a set of appropriate disincentives for health care providers determined by the HHS Inspector General to have committed information blocking.

As a national trade association of EHR developers, EHR Association member companies serve the vast majority of hospital, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs and other health IT across the United States. Together, we work to improve the quality and efficiency of care through the adoption and use of innovative, interoperable, and secure health information technology.

Implementing Disincentives for a Wider Spectrum of Healthcare Providers

ONC requests "public comment on establishing disincentives, using applicable Federal law, that could be imposed on a broader range of healthcare providers."

Those currently engaged in the Merit-Based Incentive Payment System (MIPS), Promoting Interoperability (PI), or an Accountable Care Organization (ACO) already utilize Certified EHR Technology (CEHRT) and likely adhere, for the most part, to patient transparency and interoperability standards through their obligations in those programs. Conversely, providers exempt or ineligible for these programs, such as small practices with PI exemptions, ambulatory surgical centers, long-term care facilities, and laboratories, are less likely to have access to interoperable technology and consequently more likely to have challenges meeting requirements for exchange.

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The EHR Association suggests that the proposed focus on disincentives for users of CEHRT only appears contradictory to ONC's prior emphasis that all providers should engage in information sharing, irrespective of their use of CEHRT. We propose that ONC conducts an analysis to determine how many information blocking complaints received to date pertain to providers falling within the scope of disincentives outlined in this proposal.

Distinct disincentives tailored to each category may be needed for providers outside of this scope. For instance, the incorporation of disincentives into other Centers for Medicare & Medicaid Services Innovation (CMMI) programs might impact small practices but would be unlikely to affect ambulatory surgical centers, long-term care facilities, or laboratories. A thorough understanding of the specific areas requiring attention will enable the Department of Health and Human Services (HHS) to devise the most effective plan for addressing information blocking and encourage providers regulated by other areas of CMS and HHS more broadly to expand their information sharing practices. The goals of the program will be jeopardized if an appropriate breadth of providers do not have sufficient incentive to refrain from information blocking.

Addressing Disincentives Through PI, MIPS, and ACOs

Building on the concern outlined above that the proposed rule takes a very narrow approach to who would be affected by the possible disincentives, the suggestion that only those who participate in the PI, MIPS, and ACO programs would be subject to disincentives would leave out eligible providers who choose not to participate and even some who do but are indifferent to missing an incentive payment. Compliance with information blocking regulations is based in part on organizations' commitments to active participation in a connected health data environment, and some may find that they are not motivated to change behaviors based on the proposed financial impacts. We recognize that HHS felt limited in its legal authority to consider other approaches to affect a wider array of healthcare organizations in a more significant way, but we are concerned that the current framework will do little to convince those who are reticent to embrace information sharing as a foundational strategy for their organization.

In reacting to the specifics proposed within the proposed rule, the EHR Association requests clarification regarding how information blocking actions will be attributed to specific providers or facilities within a multi-provider practice or multi-facility organization. In scenarios where responsibilities for configuring and maintaining health information technology (IT) are delegated to system administrators acting in accordance with organizational policies, determining attribution is particularly complex. We believe it is possible that the suggested attribution practices could discourage group submissions for the Merit-Based Incentive Payment System (MIPS), particularly when the actions of one group member could significantly impact the potential disincentive for the entire group. What are the potential implications for the new MIPS subgroup reporting?

Drawing from experiences in audits conducted under the Meaningful Use program, EHR developers were occasionally tasked with providing evidence of system configuration items that fell under the healthcare organization's responsibility, not the developer's. For example, EHR developers might be asked to confirm if a hospital had enabled drug-drug and drug-allergy checking, even though the EHR developer was not responsible for configuring or monitoring the usage of that feature within the organization. In these instances, requests for evidence related to system configuration and usage should

be directed to the healthcare organization responsible for those settings. In the context of this information blocking disincentive program, the EHR Association recommends that requests for evidence pertaining to system configuration and usage be directed to healthcare organizations. We commit to continuing to support our clients in understanding how to use their systems to gather the necessary evidence as needed.

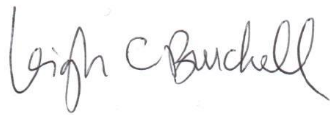
The Association has long advocated for access, use, and exchange of health information and compliance with information blocking regulations, as outlined in the Good Information Sharing Practices guide published in March 2023 by the Association's Information Blocking Compliance Task Force. We appreciate the opportunity to review proposed rulemaking as you work to fulfill the requirements of the 21st Century Cures Act. The members of the EHR Association remain available to you and your team to provide ongoing partnership and industry insights.

Sincerely,

David J. Bucciferro
Chair, EHR Association
Foothold Technology

William J. Hayes, M.D., M.B.A.
Vice Chair, EHR Association
CPSI

HIMSS EHR Association Executive Committee



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Altera Digital Health

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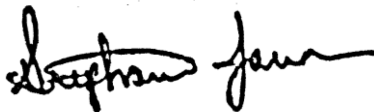

Stephanie Jamison
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Established in 2004, the Electronic Health Record (EHR) Association is comprised of 29 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families. The EHR Association is a partner of HIMSS. For more information, visit www.ehra.org.