EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

350 North Orleans Street, Suite S10000
Chicago, IL 60654

@EHRAssociation | ehra.org

November 11, 2022

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

The HIMSS Electronic Health Record (EHR) Association is pleased to provide commentary to inform rulemaking for the advanced explanation of benefits (AEOB) and good faith estimate (GFE) requirements of the No Surprises Act, in response to Request for Information CMS-9900-NC.

As a national trade association of EHR developers, our 30 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, including by supporting the numerous practices they have adopted to secure sensitive patient information. Together, we work to improve the quality and efficiency of care through the adoption and use of innovative, interoperable, and secure health information technology.

We offer the following considerations regarding this request for information.

Sincerely,

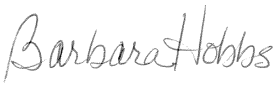
Hans J. Buitendijk
Chair, EHR Association
Cerner Corporation

David J. Bucciferro
Vice Chair, EHR Association
Foothold Technology

HIMSS EHR Association Executive Committee

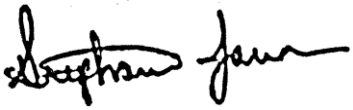
Pamela Chapman
Experity

William J. Hayes, M.D., M.B.A.
CPSI



Barbara Hobbs
MEDITECH, Inc.

Cherie Holmes-Henry
NextGen Healthcare



Stephanie Jamison
Greenway Health

Sasha TerMaat
Epic

Established in 2004, the Electronic Health Record (EHR) Association is comprised of 30 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.

What issues should the Departments and OPM consider as they weigh policies to encourage the use of a FHIR-based API for the real-time exchange of AEOB and GFE data?

The primary issue to be considered is the maturity of existing FHIR-based implementation guidance, particularly for cases in which the care plan requires input from multiple providers using disparate systems. The current guidance, which is in the early stages of development and has not been published, only addresses how to communicate a set of planned services and resources once that set has been compiled. It does not address how parties contribute to such a list.

Viability depends on collaboration across multiple providers to define the anticipated set of services and resources that will contribute to the care plan for the AEOB and GFE. The complexities of this aspect of the workflow call for clarity regarding how collaboration will be supported, how anticipated services and resources will be defined, and, consequently, how the respective contributing providers' health IT will need to interact. Without clear guidance, it will not be possible to manage complex estimates – those that would be most impactful for patients – in a predictable, standards-based fashion.

The EHR Association suggests that agencies work closely with ONC to advance the necessary implementation guidance development. Specifically, connectathons are helpful in informing guidance, while initial proof of concepts and pilot programs with early adopters will help to identify standards critical to enabling this workflow.

What privacy concerns does the transfer of AEOB and GFE data raise, considering these transfers would list the individual's scheduled (or requested) item or service, including the expected billing and diagnostic codes for that item or service? Does the exchange of AEOB and GFE data create new or unique privacy concerns for individuals enrolled in a plan or coverage?

Transmission of the necessary data to provide a GFE largely resembles the information necessary to perform a prior authorization, or that may be used for the final billing of services. We do not foresee substantially different or new privacy concerns – particularly for those patients who seek to have the services paid for by their insurance carrier, or for providers who will bill the patient in part or in full for services performed.

However, as the GFE may be used for patients to compare alternatives, including within or outside of the jurisdiction or state in which they live, there is a need for clarity and transparency regarding what impact, if any, such choices have. Currently, privacy policies vary widely and are not easily shareable

and/or computable to enable health IT to aid in this process. Clarity on privacy policies and patient consent directives across all jurisdictions is crucial to enable health IT to appropriately share health information while preserving patients' privacy in accordance with applicable jurisdiction policies.

The EHR Association recommends the departments and agencies work with ONC and health IT industry stakeholders to advance the availability of computable privacy policies. Doing so will enable health IT to support providers and patients in understanding what data can be shared within and across jurisdictions, and the potential consequences of sharing such data – whether documented clinical data or anticipated/planned clinical services.

How could updates to this program support the ability of providers and facilities to exchange GFE information with plans, issuers, and carriers or support alignment between the exchange of GFE information and the other processes providers and facilities may engage in involving the exchange of clinical and administrative data, such as electronic prior authorization?

The flexibility of technology and supporting interoperability standards is important as more complex workflows develop that involve interactions across providers and payers, as well as among health IT within their respective IT infrastructures. We note that in the prior authorization workflow some of the steps require the use of X12 where data is to be exchanged with a payer. However, that may not be the most suitable standard to use considering other steps in the workflow are better suited to using alternative standards such as HL7 FHIR, CDS Hooks, and SMART. CMS provided flexibility through an exception process to enable exploration and use of HL7 FHIR in the prior authorization workflow rather than requiring translations between FHIR and X12 to meet current regulatory requirements.

The EHR Association recommends considering flexibility in the choice of interoperability standards for end-to-end support of the entire workflow, i.e., whether to use all HL7 FHIR-based, or HL7 FHIR plus X12 where X12 remains akin to what is permissible in the e-prior authorization space. Furthermore, we suggest implementation should follow a staged approach in which the initial focus is not on certification to specific standards, but rather on functional requirements that can utilize emerging standards in part or in whole. Subsequent phases can identify opportunities and the need for certification to agreed-upon standards for specific interactions by both provider and payer-focused health IT.

Would the availability of certification criteria under the ONC Health IT Certification Program for use by plans, issuers, and carriers, or health IT developers serving plans, issuers, and carriers, help to enable interoperability of API technology adopted by these entities?

Standards supporting this end-to-end workflow are still in early development and certification based on immature standards carries a high risk of unnecessary costs. This is amplified when multiple health IT solutions are necessary to support the full workflow. Many providers do not use a single health IT solution across all clinical, administrative, and financial processes, yet this workflow, like prior authorization, touches on all.

While most current certified interoperability capabilities involve simple, point-to-point interactions between EHRs and other parties (e.g., public health transactions, patient access using FHIR APIs, document exchange using Direct or networks), successful management and completion of this more complex workflow involves multiple health IT solutions which must interact across multiple steps of the workflow to be successful. It is not yet clear which health IT will support which elements of this complex workflow.

The EHR Association recommends caution to avoid prematurely initiating a certification program around a complex workflow in which the interactions between the relevant health IT are not yet well understood. We suggest focusing instead on initial proof of concepts, pilots, and early implementations to establish the minimum necessary set of interactions across all relevant health IT to which standards can then be certified. As noted in a prior question, a staged approach could enable this process by creating focus, without introducing certification requirements that lack a complete understanding of the variety of health IT configurations necessary to support the full workflow.

Are there any approaches that the Departments and OPM should consider, or flexibility that should be provided (such as an exception or a phased-in approach to requiring providers and payers to adopt a standards-based API to exchange AEOB and GFE data), to account for small, rural, or other providers, facilities, plans, issuers, and carriers?

The EHR Association recommends considering an approach initially focusing on functional requirements, as it is premature to require specific standards considering the lack of maturity of the health IT and interoperability standards to support this workflow. For example, the first stage focuses on the provider or payer's ability to demonstrate a capability while not requiring certification to specific interoperability standards (although certain standards could be suggested for use in part or in whole). We note that CMS has done so in the past with various capabilities for which a provider could earn additional promoting interoperability performance points on voluntary capabilities.

Exceptions, in that case, may already be established for smaller, rural, critical access organizations until such time that health IT and standards have evolved enough to deploy these across a larger community.

If the Departments and OPM were to provide such flexibility, what factors should they consider in defining eligible providers, facilities, plans, issuers, and carriers?

Any flexibility offered to providers must also consider the health IT developers who will support the varying options made available. If providers have the flexibility to phase in utilization, health IT may still be required to offer the full solution upfront, which takes considerable time and cost to develop, test, and deploy.

The EHR Association recommends clarity of expectations and careful consideration of flexibility to providers that would yield substantially increased scope for health IT developers at the start, rather than over subsequent phases.