EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

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July 13, 2023

Judith M. Persichilli, R.N., B.S.N., M.A.
Commissioner
Department of Health
P.O. Box 360
Trenton, NJ 08625-0360

Jennifer D'Angelo
SVP & General Manager
New Jersey Innovation Institute
211 Warren St
Newark, NJ 07103

Dear Commissioner Persichilli and Ms. D'Angelo,

On behalf of the EHR Association, a 30-member trade association of EHR developers, we seek insights into the NJHIN Master Patient Index (MPI) initiative[1] that some of our collective clients have recently brought to our attention. As software developers who support the applicable healthcare organizations with the technology necessary to comply with such programs, the requests that have been coming in have raised questions about the requirement to exchange the new common key, or Common Key Service (CKS)/MPI identifier, in ADT transactions and C-CDA documents by September 2023. This timeline is not feasible for most health IT developers, and the details leave questions to be answered before we can proceed. Accordingly, we request a meeting with representatives of both the NJDOH and NJHIN to discuss our questions and how to best enable our members to support the impacted provider organizations.

Some of our questions follow:

Regulatory and Policy Drivers

1. Which bill(s) and/or regulation(s) mandate the implementation and support of this initiative?

2. Which providers, and what types of healthcare settings, are required to support these capabilities, if any, and which providers can opt to participate?

3. If participation is currently not mandatory, is there a plan and/or timeline for any other providers to be required to participate?

[1] https://www.njii.com/wp-content/uploads/2023/05/Master-Person-Index.pdf

4. Are there any penalties associated with this MPI requirement? We have heard there is a $1,000 per day fine for non-compliance beginning in September 2023. Is that accurate?

The New Jersey Innovation Institute document linked in footnote 1 would seem to imply this is a voluntary program.

Technical Requirements and Compliance

1. What are the policy objectives and scope of the requirements? Is this meant to cover only direct interactions between a provider and NJHIN, or other interactions as well? We are not clear whether the proposed approach achieves the intended goals. And, depending on the goals, whether the proposed interactions are necessary or if an alternative path is available that would be equally effective at a lower cost.

2. Can a provider be compliant with the program if they send CDA C-CDA documents conforming to ONC's Certification Program using the XDS.b protocol, i.e., using the provider's identifier that was also sent in applicable ADT messages to also enable NJHIN to perform the matching?

3. Can ADT messages that include the providers' patient identifier be used and share that patient identifier in ADT messages instead of using PIX Feeds?

4. Is the expectation that the CKS/MPI identifier is only included in the C-CDA CCD document type or any C-CDA document type shared with NJHIN?

5. Can you clarify the merging process considering the following challenges:
    a. Merges and moves can be initiated by NJHIN or the provider, depending on who discovers a match first. What are the expectations on the merge and move transactions when the provider initiates the merge? How would the respective CKS/MPI identifiers be expected to be shared?

    b. "Old" CKS/MPI identifiers are supposed to be deleted when received as part of the A31 transaction from NJHIN. Is the intent truly a "delete" or is de-activation acceptable as well? Do old identifiers get re-used?

    c. While the registration system would manage the ADT transactions with NJHIN, another system that provides the EHR could generate and submit C-CDA documents. The relevant systems within a provider's organization that would contribute the clinical data would have to be updated with the initial CKS/MPI identifier, as well as any "replacements." The process to introduce the necessary merge/move transaction updates and the actual merging process (which may require human review) will all take time. Additionally, when already-generated C-CDA documents are suitable for sharing, a prior CKS/MPI identifier would have been included. When sending a C-CDA (or other transactions at some point in time), it should therefore be acceptable for a prior

CKS/MPI to be included, and already-generated documents should not be updated or have to be re-generated to be shareable. Can you confirm this is indeed acceptable?

6. A provider's registration system is typically considered the source of truth for the provider's health IT modules. However, there is no mention of other demographic data updates or changes from the A31. Can you confirm that an A31 will never require demographic changes on the provider's side, even if A31 data may not be in sync with the provider's health IT? In that case, a separate A08 or suitable message would be used. What are plans for other transactions between the provider and NJHN that should include the CKS/MPI identifier?

7. The sample CKS/MPI values for the CKS service provided in the NJDOH specifications are longer than the HL7 field length referenced in HL7 v2.3.1, HL7 2.5.1, as well as NJHIN's ADT Implementation Guide (Section 6.4). HL7 v2.3.1 indicates for each occurrence of PID-3 to be 20, but practically when including an identifier type that would shrink below 14 or less (using CKS/MPI as the identifier type that would be 7 or less). HL7 v2.5.1 indicates a length of 15 for just the identifier value in PID-3.1 for each occurrence. And then in Hl7 v2.7, referenced by both HL7 ELR and LRI implementation guides for data lengths, a different specification is used in light of the variability in lengths. It uses a requirement for a minimum of 15 characters while truncation is not permitted. Additionally, HL7 acknowledged that the actual length needs to be agreed upon between communicating parties. We note that various systems may therefore not support a substantially longer length of up to ~40 characters for an identifier value. The changes necessary to accommodate that could be substantial. What is the maximum length that would need to be supported? What is the expectation for systems when they cannot accommodate such a length?

Based on our concerns that the complexities identified here raise technical challenges and concerns about the time it would take us to make any necessary changes and understand potential alternatives to achieve the desired goals, we would greatly appreciate the opportunity to meet at your earliest opportunity. The Association's leadership can be reached by contacting Kasey Nicholoff at knicholoff@ehra.org, who can help identify a time that will work for all stakeholders.

Sincerely,

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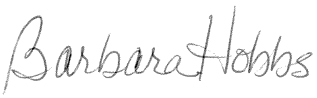

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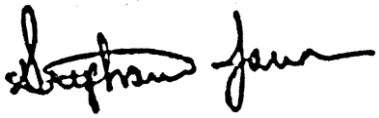

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Established in 2004, the Electronic Health Record (EHR) Association is comprised of 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that 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.

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