LeadingAge New York

December 21, 2015

Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237

Re: Addition of Part 300 to Title 10 NYCRR (Statewide Health Information Network for New York (SHIN-NY))

Dear Ms. Ceroalo:

I am writing on behalf of LeadingAge New York to offer comments on the proposed regulations governing the Statewide Health Information Network for New York (SHIN-NY) and requiring certain providers to connect to the SHIN-NY to effectuate bi-directional health information exchange.

LeadingAge New York's nearly 500 members represent the entire continuum of not-for-profit and public providers of senior housing and long-term/post-acute care (LTPAC), including home and community-based services, adult day health care, nursing homes, continuing care retirement communities, assisted living facilities, hospice programs, and managed long term care programs.

We support the State's efforts to create a "public good" model of health information exchange. We recognize that robust, bi-directional health information exchange is critical to the success of new models of care and payment that promise to advance the Triple Aim of better health, better care and lower costs. However, we are concerned about the requirement that non-hospital providers utilizing certified electronic health records (EHRs) become qualified entity participants, in order to connect to the SHIN-NY and allow bi-directional access to patient information within two years. (Proposed 10 NYCRR §300.6(a)). As currently drafted, the regulation does not clearly identify the categories of providers that are subject to this requirement. We assume that this requirement would *not* apply to LTPAC providers, and we would oppose the imposition of such a requirement on LTPAC providers in the absence of a significant commitment of public resources to support building connections between LTPAC providers and qualified entities.

Specifically, the requirement is triggered by the adoption of "certified electronic health record technology under the federal Health Information Technology for Economic and Clinical Health Act (HITECH)." (Proposed 10 NYCRR §300.6(a)). The meaning of this phrase and its applicability to LTPAC providers and other providers that are ineligible for meaningful use incentives under HITECH is unclear. For these categories of providers, which include among others LTPAC and behavioral health

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providers, meaningful use certification is voluntary. As a result, there is no recognized certification under the HITECH Act for LTPAC EHRs. Some LTPAC EHRs, however, *are* ONC-Authorized Testing and Certification Body (ONC-ATCB) certified for particular modules applicable to LTPAC. We assume that the requirement to connect to a qualified entity would *not* apply even to LTPAC EHRs with ONC-ATCB certification. Accordingly, section 300.6 should be amended to clarify that LTPAC providers and other providers that are not eligible for meaningful use incentives are exempt from this requirement.

Although our members are eager to connect to regional health information organizations (RHIOs) and participate in bi-directional exchange of patient information with their care partners, many lack the resources to build these connections. Even with an ONC-ATCB certified EHR, building a connection between the EHR and a RHIO or qualified entity can be a costly undertaking. According to the proposed regulation's impact analysis, the cost to connect to the SHIN-NY will vary for LTPAC providers between $10,000 and $75,000, depending on size and complexity.

Unlike general hospitals and physician practices, LTPAC providers have received minimal public investment in health information technology. The regulatory impact statement cites various public programs that have provided support for EHR adoption and health information exchange. However, a negligible portion of those funds has been invested in the LTPAC sector. Of approximately $324 million invested in health information technology (health IT) through HEAL New York Phases 1, 5, 10 and 17, only approximately $6 million (less than 2 percent) was awarded to projects targeting LTPAC providers.[1] While some large HEAL awardees included a handful of LTPAC providers among their partners, the overwhelming majority of the funds flowed to RHIOs, hospitals, and physician practices or clinics. HEAL New York Phase 22 was dedicated to behavioral health providers participating in health homes. We could not find a list of HEAL 22 awardees on the Department's website, but we understand that it did not benefit the LTPAC sector.

DSRIP payments through performing provider systems (PPSs) do not appear to be poised to fill this gap in health information technology investment. Based on our analysis of the PPS first quarterly reports, only 4.2 percent of DSRIP incentive payments are projected to flow to nursing homes over the next five years, only 3.6 percent to community-based organizations, and only 1.1 percent to hospice programs.[2] More recently, State grant programs have excluded LTPAC providers (including nursing homes) because they are not considered hospitals (i.e., Essential Healthcare Provider Support Programs) or have excluded nursing homes because they *are* considered hospitals (i.e., Nonprofit Infrastructure Capital Investment Program).

Given the lack of an approved certification for LTPAC EHR products, and the lack of funding for LTPAC providers to support connections to qualified entities, the regulation should be clarified to exempt LTPAC providers from the requirement to connect to qualified entities and engage in bi-

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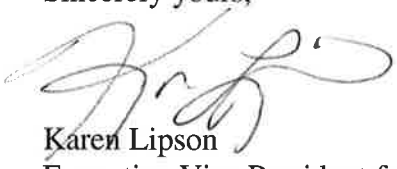
[1] LeadingAge New York analysis of HEAL Phases 1, 5, 10 and 17 awards.

[2] LeadingAge New York analysis of DSRIP PPS First Quarterly Reports, Module 1.2, available at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/first_quarterly_report.htm . Amounts dedicated to home care agencies and assisted living programs are not specifically identified in the quarterly reports. We assume that they are included in the community-based organization category.

directional health information exchange. Although the regulation does provide a waiver process, we are concerned that if the requirement is applied to LTPAC providers or does not clearly exempt them, it will lead to a deluge of waiver applications and additional administrative burdens and uncertainty for both the Department and providers.

Thank you very much for the opportunity to comment.

Sincerely yours,



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