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Via E-mail

Malinda Southard, DC, CPM
Deputy Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
msouthard@dhcfp.nv.gov

Dear Dr. Southard,

Thank you very much for the opportunity to answer your questions on behalf of HealtHIE Nevada, and to note the specific sections and/or subsections in AB7 applicable to these suggested revisions, and to briefly share our thoughts regarding our approach to the proposed regulation.

As discussed briefly with Mr. Lither, we have proposed these revisions to the "first draft" of the regulation that you distributed in advance of the last EHIAG meeting. For your convenience, we have also provided a "Compare" version to show our work.

First and foremost, we tried to incorporate all the notes that you made during the meeting incorporating comments and impromptu revisions from EHIAG members (I hope we didn't miss anything), and we tried to work out language that addressed specific concerns raised by group members. We also distinguished and made consistent some of the proposed language and terms. We trust those changes are self-explanatory and not controversial.

Secondly, regarding the added sections on "Contracted Statewide Health Information Exchanges," we are responding to the changes and rulemaking authority found in Section 1.06 of AB7 and NRS 439.587(2) and (3), for the Director to "establish or contract with one or more health information exchanges to be responsible for compiling statewide master indexes of patients, health care providers and payers. The Director may by regulation prescribe the requirements for such a health information exchange . . ." and may "enter into contracts, apply for and accept available gifts, grants and donations, and adopt such regulations as are necessary to carry out the provisions of NRS 439.581 to 439.595, inclusive , and section 1 of [AB&7]." As there is no existing framework or criteria in the regulations by which the Director may proceed, we have suggested a fair and impartial framework for the Director to contract "on commercially reasonable terms acceptable to the Director and the Department," with a "contracted statewide health information exchange" ("CSHIE"). CSHIE is an existing concept in NRS 439 and a critical component of the evolving architecture of health information exchange ("HIE"). Accordingly, we specify the requirements for such a CSHIE to operate, and give the Director the discretion to contract with one.

There seems to be broad consensus among the EHIAG members (many that we've heard from, at least) for what's included here in this proposed Second Draft, but we leave that to your judgement and the deliberations of the Group.

Regarding the four themes that Michael noted and specific citations:

1. **The ability to manage informed consent (opt-in) for all participants is addressed in Section 1.09 of AB 7.**

Sec. 1.09 of AB 7, amending NRS 439.591, provides that, "[b]efore a patient's health care records may be retrieved from a health information exchange, the patient must be fully informed and affirmatively consent, in the manner prescribed by the Director….[and] a patient's health care records must not be retrieved from a health information exchange unless the patient provides such affirmative consent."

HealtHIE Nevada's proposed regulations implement AB 7 and comply with existing regulations in Chapter 439 of the NAC (e.g. NAC 439.592) by requiring that a CSHIE "*[c]omply with the consent laws codified in this Chapter and Chapter 439 of the NRS, including demonstrating the ability to collect patient consent form submissions and consistently comply with patient consent decisions."*

2. **A master patient index and provider index is addressed in Section 1.06 of AB 7.**

Section 1.06 of AB 7, amending NRS 439.587(2), provides that "[t]he Director may establish or contract with one or more health information exchanges to be responsible for compiling statewide master indexes of patients, health care providers and payers." AB 7 further states that the Director "may by regulation prescribe the requirements for such a health information exchange, including, without limitation, the procedure by which any patient, health care provider or payer master index created pursuant to any contract is transferred to the State upon termination of the contract."

This provision of AB 7 is consistent with existing regulations (NAC 439.576(5)) which already require that a HIE that operates in Nevada "[u]se an enterprise master patient index and a master provider index for the secure and efficient exchange of health information."

HealtHIE Nevada's proposed regulations implement this provision of AB 7 and are consistent with AB 7 and existing regulations by requiring that a CSHIE "[m]*aintain and operate statewide master indexes of Providers, patients, and payers that comprise a diverse and substantial number of Providers, patients, and payers in the State" and "[h]ave procedures in place acceptable to the Department by which its statewide master indexes will be transferred to the Department upon termination of its contract."* This is the consensus approach.

3. <u>Technical capabilities to (a) initiate and respond to patient data queries, and (b) to process transactions (results delivery, event notifications, pushing of medical records to EHRs when required, etc.) are addressed in Section 1.08 of AB 7.</u>

Section 1.08 of AB 7, amending NRS 439.589(1), provides that "[t]he Director, in consultation with health care providers, third parties and other interested persons and entities, ***shall by regulation prescribe a framework*** [emphasis added] for the electronic maintenance, transmittal and exchange of electronic health records, prescriptions, health-related information and electronic signatures and requirements for electronic equivalents of written entries or written approvals in accordance with federal law."

This subsection of AB 7 further states that these regulations must accomplish the following:

(1) Establish standards "*for networks and technologies to be used to maintain, transmit and exchange health information, including, without limitation, standards….[t]hat require…. [t]he use of networks and technologies that allow patients to access electronic health records directly from the health care provider of the patient and forward such electronic health records electronically to other persons and entities*" and "*[t]he interoperability of such networks and technologies in accordance with the applicable standards for the interoperability of Qualified Health Information Networks prescribed by the Office of the National Coordinator for Health Information Technology of the United States Department of Health and Human Services*."
(2) Establish standards that require "*[g]overning the ownership, management and use of electronic health records, health-related information and related data*."
(3) Establish standards that *"[e]nsure compliance with the requirements, specifications and protocols for exchanging, securing and disclosing electronic health records, health-related information and related data prescribed pursuant to the provisions of the Health Information Technology for Economic and Clinical Health Act, 42 U.S.C. §§ 300jj et seq. and 17901 et seq., the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and other applicable federal and state law*."
(4) Establish standards that are "*based on nationally recognized best practices for maintaining, transmitting and exchanging health information electronically*."

HealtHIE Nevada's proposed regulations comply with AB 7 by requiring that a HIE seeking to become a CSHIE demonstrate, among other reasonable requirements, the ability to comply with the following requirements: (1) "[p]*erform communication and information transactional services, including, but not limited to, event notification, delivery of lab results, sending discharge summaries, and other real time transactions*"; (2) "[c]*oordinate and connect with national exchange networks (e.g., a Qualified Health Information Network (QHIN))*"; and (3) "[d]*emonstrate transactional capabilities to create and maintain a patient information communication network to facilitate the push, pull, and expeditious transfer of patient information and notices regarding patient health*."

4. Capabilities for public health and population health – this is a consensus requirement, and consistent with the Director's pre-existing authority under NRS 439.576 and AB 7's provisions regarding consistency with nationally recognized best practices.

As indicated by the comments of several EHIAG members directly involved in public health administration, public health and population health are among the *raisons d'etre* for CSHIE-like entities around the world. Several members attested that these core functions are "nationally recognized best practices for" CSHIE-like entities, and there is broad and longstanding consensus around the country this these are key reasons for CSHIE-like entities to exist. *See* Using Health Information Exchange to Improve Public Health, Am J Public Health. 2011 April; 101(4): 616–623, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052326/

Though these specific terms do not appear in AB7, they are already in NRS 439, are concepts familiar to the EHIAG members, and also respond to the desires expressed by the Director. They are consistent with the existing requirements of NAC 439.576 that were in place before and after enactment of AB 7 for HIEs generally, which require that a Nevada HIE: "2. Facilitate the sharing of health information across the public and private sectors to increase efficiency and improve outcomes of health care in this State; [and] 3. Support public health and population health initiatives and collaboration between organizations and governmental entities working in the fields of public health and population health". Thus, including more detailed regulations regarding what a CSHIE must do in order to be considered as having the capability to provide data for public health and population health purposes for Nevada is consistent with and a natural extension of these requirements.

HealtHIE Nevada's proposed regulations also complement the existing requirements of NAC 439.576 by adding requirements that a CSHIE "j. Provide public health services, including, but not limited to, electronic lab reporting, syndromic surveillance, immunizations coordination, population health analyses, public health analyses, and medical research coordination among Providers or members of academia".

Given the sheer amount and quality of information that would exist on a CSHIE, the public obligations of the CSHIE, and the potential to improve public health that this information presents, and consistent with the best practices of other states, it seems axiomatic that a CSHIE should be required to perform these functions. Accordingly, we included them as requirements.

We hope this is responsive to your questions and concerns, and we are happy to assist you further. Please feel free to contact us at your convenience.

Thank you for all you do!

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