



June 16, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1771-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1771-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Comments submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure:

The American Medical Informatics Association (AMIA) appreciates the opportunity to comment on the proposed FY 2023 Hospital Inpatient Prospective Payment System rule. AMIA is the professional home for more than 5,500 informatics professionals, representing frontline clinicians, researchers, and public health experts who bring meaning to data, manage information, and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations.

AMIA commends the Centers for Medicare and Medicaid Services (CMS) for its commitment to advance health equity, improve quality measurement, foster data collection to improve population health, and promote interoperability across the healthcare ecosystem. We offer comments on these important topics.

Social Determinants of Health (SDOH) Diagnosis Codes

In this proposed rule, CMS seeks comments on how the reporting of SDOH diagnosis codes may improve the ability to recognize severity of illness, complexity of service, and/or utilization of resources under the MS-DRGs. CMS seeks feedback on how to foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to more accurately reflect each health care encounter and improve the reliability and validity of the coded data, including in support of efforts to advance health equity.

In general, AMIA supports a deliberate yet incremental approach to the expansion of data collection initiatives. A balance must be achieved between the addition of data fields and a recognition of the need to minimize burden on front line providers. Further, there is a need to tie data collection to clinical relevance. The value of data collection is well established for quality and safety, and appropriate data to inform policy making will be of utmost importance as collectively we strive to achieve health equity and reduce health disparities.

AMIA believes this data collection proposal should be viewed in the landscape of other data collection initiatives across federal government programs, to ensure that additional data collection will inform policies to advance health equity. Further, we caution that due to the uniquely sensitive nature of SDOH data, emphasis should be placed on practices for uniform data collection methods, with paramount respect for patient privacy.

AMIA supports better integration, interoperability, and bi-directional sharing of data, information, and knowledge across care delivery, public health agencies, and community-based organizations. Such data are necessary to inform policy, drive prevention and disease management efforts, and support community resource information sharing. While each of the CMS proposals outlined in this rule to drive enhanced data collection are important, it is equally important to be realistic in expectations for use of data. Bi-directional sharing of data is critical. But there may be variability between practice of States or other entities, depending upon their respective capacity to effectively collect, disseminate, communicate, and foster data use to drive needed improvements in health care delivery for underserved populations.

We provide the following references for CMS' consideration.

Himmelstein G, Bates D, Zhou L. Examination of Stigmatizing Language in the Electronic Health Record. JAMA Netw Open. 2022;5(1):e2144967. [Examination of Stigmatizing Language in the Electronic Health Record - PubMed \(nih.gov\)](#)

Klinger EV, Carlini SV, Gonzalez I, Hubert SS, Linder JA, Rigotti NA, et al. Accuracy of race, ethnicity, and language preference in an electronic health record. J Gen Intern Med. 2015;30(6):719-23. [Accuracy of race, ethnicity, and language preference in an electronic health record - PubMed \(nih.gov\)](#)

Disparities Measurement

CMS seeks comments on guiding principles for use and application of results of disparities measurement. AMIA believes the following core principles should be incorporated in any effort to systematically collect and measure disparities across all programs administered by CMS.

1. Autonomy - All people must be treated with equity, courtesy, and respect, especially when collecting data that are highly sensitive and are in domains or conditions that may be subject to inherent bias or perceived stigma.
2. Beneficence – the process from data collection through data governance must be modeled after compassionate, kind, and considerate human behavior.
3. Non-maleficence – the process should “do no harm” by avoiding, preventing, and minimizing harm or damage to any stakeholder including related to future interoperability sharing.
4. Justice – the process must centrally support the aim of health equity.
5. Explainability - the purpose, scope, use, and limitations of data collection must be presented to the patient in concise, understandable language. Potential interpretations of the data into policy may also need to be made explicit.
6. Fairness – the process must be thoughtful in defining and reducing implicit bias and must support non-discriminatory data collection and use.
7. Confidentiality – Central emphasis must be placed on developing highly reliable approaches to protect an individual’s confidentiality while implementing strategies to improve population health outcomes. The practices may need to be refined as health information protections advance as a discipline, given the sensitivity of the information being collected.

Inpatient Quality Reporting

CMS proposes the adoption of Hospital Commitment to Health Equity measure beginning with the CY 2023 reporting period/FY 2025 payment determination. This would be an attestation based structural measure based on five domains and elements as outlined in the proposed rule.

AMIA believes the domains and elements proposed by CMS appropriately support an affirmative attestation to the Hospital Commitment to Health Equity Structural Measure. While “Social” and “Family History” have long been elements of the medical history elicited by providers, that information has not frequently led to interventions outside traditional clinical assessments and plans. Emerging recognition of the relationship between health disparities and equity makes this proposed Equity measure both timely and instructive. We suggest that most hospitals do not currently have all of these elements in place, nor have they fully identified the goals and actions needed to robustly impact equity issues in their environments. Attestation to this measure in 2023 might require the adoption of an equity framework that incorporates all of the proposed domains. CMS should then seek to incentivize hospitals to fully implement a

meaningfully impactful equity program over the next several years. In particular, we believe the evolving FHIR ecosystem is a necessary enabler of equity information management.

Transition to Digital Quality Measurement

CMS seeks comment on continued advancements to digital quality measurement and the use of the FHIR® standard for electronic clinical quality measures (eQMs). CMS defines digital quality measures (dQMs) as “quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems.”

AMIA suggests the initial focus of dQMs should remain “measures that emphasize the use of data available in EHRs (and other data) gathered in the routine processes of care.” A major concern as we prepare to enable access to Electronic Health Information (EHI) this fall is that platforms are not yet available to support electronic capture, extraction, and access from non-EHR data sources. An ultimate convergence of USCDI with core EHI facilitated by FHIR standards, resources, and technology will enable further development and assure completeness and accuracy of dQMs while reducing burden associated with manual data preparation.

Advancing TEFCA

CMS states its belief that exchange of health information enabled by the Common Agreement can advance CMS policy and program objectives related to care coordination, cost efficiency, and patient-centeredness. CMS also believes that CMS policy and programs can help to accelerate nationwide connectivity through TEFCA by health care providers as well as other stakeholders.

AMIA believes TEFCA can further facilitate the attainment of these goals if it successfully incorporates and augments major existing exchange frameworks such as Common Well, Care Everywhere, Carequality, eHealth Exchange and the nation’s networks of Health Information Exchanges. These existing platforms and networks exchange millions of packets of information daily but absent a globally accepted and adopted Common Agreement exchanged data often fails to meaningfully impact clinical care. We appreciate the incremental and evolutionary approach ONC and the Sequoia Project (the TEFCA Recognized Coordinating Entity) are taking (<https://www.healthit.gov/buzz-blog/interoperability/321tefca-is-go-for-launch>). As the TEFCA gains adoption, we suggest CMS further incentivize moving from voluntary participation by offering additional opportunities to participants in the Meaningful Use/Promoting Interoperability programs. As TEFCA matures ONC should consider inclusion of TEFCA-supporting requirements in their certification programs.

Promoting Interoperability

Under this proposed rule, CMS proposes the following changes to the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals (CAHs).

- Add a new Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure under the Health Information Exchange (HIE) Objective as a yes/no attestation measure, beginning with the EHR reporting period in CY 2023, as an optional alternative to the three existing measures under the HIE Objective. This proposed measure would provide eligible hospitals and CAHs with the opportunity to earn credit for the Health Information Exchange objective if they: are a signatory to a “Framework Agreement” as that term is defined in the Common Agreement; enable secure, bi-directional exchange of information to occur for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23), and all unique patient records stored or maintained in the EHR for these departments; and use the functions of certified EHR technology (CEHRT) to support bi-directional exchange.

AMIA agrees this incentivizes participation and supports adding this as an option.

- Institute public reporting of certain Medicare Promoting Interoperability Program data beginning with the CY 2023 EHR reporting period.

AMIA supports this provision.

- Beginning with the CY 2023 EHR reporting period, CMS proposes to require submission of the level of active engagement (moving toward sending data to a public health agency or registry, sending data, or has completed registration to submit data; testing and validation; electronically submitting production data), in addition to submitting the measures for the Public Health and Clinical Data Exchange Objective. Current measures are: immunization registry reporting; syndromic surveillance reporting; electronic case reporting; electronic reportable lab result reporting; public health registry reporting; clinical data registry reporting.

AMIA supports this provision. Again, we emphasize that bi-directional sharing of data, information, and knowledge is integral to achieve a meaningful change in health care delivery practices. We note that local and state health departments have limitations and variable levels of the technical resource needed to develop interfaces and infrastructure necessary to support exchange of these data classes. To the extent possible CMS and other Federal agencies such as CDC should support the states’ development efforts including the development and publication of exchange standards and implementation guides.

- Beginning with CY 2023 EHR reporting period, CMS proposes to increase the Public Health and Clinical Data Exchange Objective from 10 to 25 points, to increase the points associated with the Electronic Prescribing Objective from 10 to 20, to reduce the points associated with the Health Information Exchange Objective from the current 40 points to 30 points, and to reduce the points associated with the Provide Patients Electronic Access to Their Health Information from the current 40 to 25 points.

AMIA recognizes and applauds efforts to further incentivize electronic prescribing. We are mindful that points may need to be reallocated to address critical public health objectives. However, we ask CMS to remain mindful that policies, programs, research and care delivery should seek to empower patients through access to, and control of, their personal health information. It is important that patient access to their electronic health information remain a priority across all care settings.

Hospital Reporting of Data Elements to Address Future Pandemics

In this proposed rule, CMS would require hospitals to report specific data elements (on a daily basis) to the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN), or other CDC-supported surveillance systems, as determined by the Secretary of Health and Human Services (HHS). This would apply to local, state, and national Public Health Emergencies (PHEs) declared by the Secretary of HHS.

AMIA strongly supports this provision. The COVID-19 PHE has illuminated the deficiencies of our nation's public health infrastructure. As long-time proponents of proposals to emphasize public health reporting in Promoting Interoperability, we believe it is critical to advance real-time, electronic data exchange from hospitals and providers to public health agencies. In support of this need, we further urge CMS to consider the necessity to bolster infrastructure resources and support to enable hospitals that may be lower-resourced to be able to contribute efficiently and support data to surveillance systems without undue strain. We consider the use-cases of safety net hospitals and rural hospitals, that may face particular challenges ranging from data collection, input, and reporting. Recognizing the importance of all institutions, and particularly those that care primarily for underserved patient populations, AMIA supports efforts to ensure the inclusion of crucial health data to inform public health initiatives using key metrics.

Thank you for your consideration of these comments. If you have question or require additional information, please contact Peter J. Mihalick, Esq., AMIA Vice President, Public Policy, at pmihalick@amia.org.

Sincerely,

A handwritten signature in blue ink that reads "Gretchen P Jackson". The signature is fluid and cursive, with the first name "Gretchen" being more prominent than the last name "Jackson".

Gretchen Purcell Jackson, MD, PhD, FACS, FACMI, FAMIA
President and Board Chair, American Medical Informatics Association