June 24, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1716-P
Submitted electronically http://www.regulations.gov

Re: 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 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals Dear Administrator Verma:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the FY2020 Hospital Inpatient Prospective Payment Systems proposed 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 supports CMS proposals that provide hospitals with flexibilities in how they comply with the Promoting Interoperability Program and incentivize hospitals to continue investments in health information technology (IT) for patient care. For example, we applaud CMS efforts to continue a 90-day reporting period and give hospitals the option to report on the Query of PDMP measure. We also support the inclusion of a possible bonus under the Provider to Patient Exchange objective for early adoption / deployment of (g)(10)-certified APIs.[1]

As articulated in our FY2019 IPPS proposed rule comments,[2] we again urge CMS to more aggressively pursue a Promoting Interoperability Program that abandons the constructs of measure reporting in favor of (1) setting clear deadlines for adoption of new certification functionality and (2)

[1] The term "*(g)(10)-certified API"* is reference throughout ONC's preamble at 84 FR 7424 to refer to health IT certified to the certification criterion proposed for adoption in 45 CFR 170.315(g)(10). Available at: https://www.federalregister.gov/documents/2019/03/04/2019-02224/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification

[2] AMIA Response to CMS FY19 IPPS NPRM (83 FR 20164). June 25, 2018. Available at: https://www.amia.org/sites/default/files/AMIA-Response-to-CMS-2019-IPPS-NPRM.pdf

enabling organizations to demonstrate clinically meaningful use of health IT for their specific patient populations and priorities through activity-based approaches, such as Inpatient Improvement Activities (IIAs).

Adopt clear deadlines for provider deployment of certified health IT

In recent comments to both ONC[3] and CMS,[4] AMIA strongly recommended CMS re-assert its jurisdictional purview to establish industry adoption timelines for health IT, rather than cede this responsibility to ONC. In the ONC NPRM several provisions dictate both development and deployment timelines for certified health IT.[5] To our knowledge, ONC's proposals represent the first instance where the Office assumed both roles: dictating development and deployment timeline requirements. In comments we urged ONC only to establish development timelines and leave certified health IT adoption requirements for hospitals and clinicians to CMS.

AMA again urges ONC and CMS to work collaboratively in setting requirements for development and adoption of certified health IT. Further, we encourage CMS to leverage certification when appropriate to better ensure that providers who are required to adopt IT for specified functionality have what they need to fulfill the requirement, rather than require specific uses of health IT without certification criteria. This division of regulatory authority provides stability for regulated industry, accountability for regulators, and transparency for all stakeholders.

End numerator/denominator-driven measurement in the Promoting Interoperability Program

Designing technology according to the imperative of capturing a numerator and denominator for tasks as varied and complex as clinical care has created dozens of fluctuating requirements leading to short-term workarounds and administrative burden. And perhaps most insidious, numerators and denominators required by CMS have negatively impacted the design and usability of EHRs while perversely impacting clinical workflow. While we appreciate various Requests for Information (RFIs) posed by CMS meant to improve the safety and safe use of EHRs or promote the integration of patient-generated health data (PGHD) in EHRs, more steps should be taken to initiate conversations regarding the contours and additional characteristics of acceptable IIAs. Such an approach should replace functional measures prescribed by CMS with clinically-relevant IIAs that can address both local/regional priorities and strategic areas for HHS. We recognize the difficulty in crafting a program relevant to an array of inpatient settings across the country, so we further recommend that pilots be initiated through the CMS Innovation Center (CMMI) to understand what

[3] AMIA Response to ONC 21st Century Cures Act NPRM (84 FR 16834). May 23, 2019. Available at: https://www.amia.org/sites/default/files/AMIA-Response-to%20-ONC-Cures-NPRM.pdf
[4] AMIA Response to CMS Patient Access and Interoperability NPRM (84 FR 7610). June 3, 2019. Available at: https://www.amia.org/sites/default/files/AMIA-Response-to-CMS-Interop-and-Patient-Access-NPRM_0.pdf
[5] These functionalities include the need to have deployed APIs (§170.315(g)(10)), the ability to provide both a EHI Export for Patient Access (§170.315 (b)(10)(i)) for patients; and an Assurance Condition & Maintenance of Certification requirement that updates the definition of Base EHR at §170.315(b)(10) for which all providers must possess.

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4720 Montgomery Lane, Suite 500 | Bethesda, Maryland 20814

systems and controls are needed to support a Promoting Interoperability Program absent numerator and denominator measures.

Below, we provide specific comments on the Requests for Information (RFI) in this NPRM. We hope our comments are helpful as you undertake this important work. Should you have questions about these comments or require additional information, please contact Jeffery Smith, Vice President of Public Policy at jsmith@amia.org or (301) 657-1291. We look forward to continued partnership and dialogue.

Sincerely,

Douglas B. Fridsma, MD, PhD, FACP, FACMI
President and CEO
AMIA

Peter J. Embi MD, MS, FACP, FACMI
AMIA Board Chair
President & CEO
Regenstrief Institute

(Enclosed: Detailed AMIA Comments regarding CMS' FY20 IPPS NPRM)

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Proposed EHR Reporting Period in CY 2021

For CY 2021, CMS is proposing an EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants (eligible hospitals and CAHs) in the Medicare Promoting Interoperability Program attesting to CMS.

AMIA Comments: AMIA agrees with CMS's reasoning in the NPRM and supports the continuation of this flexibility that will allow more eligible hospitals and CAHs to successfully participate in the PI Program.

Proposed Changes to Measures Under the Electronic Prescribing Objective

Query of PDMP Measure

CMS is proposing to make the Query of PDMP measure optional in CY 2020 and eligible for 5 bonus points. They are also proposing that, in the event they finalize these changes, the e-Prescribing measure would be worth up to 10 points in CY 2020 and subsequent years.

In addition, beginning with the EHR reporting period in CY 2019, CMS is proposing to remove the numerator and denominator that CMS established for the Query of PDMP measure in the FY 2019 IPPS/LTCH PPS final rule and instead require a "yes/no" response.

AMIA Comments: AMIA is very pleased with the proposed changes. We do not believe such a measure should be required until CEHRT supports it. Further, we wholeheartedly support the removal of the numerator/denominator criteria for the measure. We hope that this is the first step in CMS moving away from a numerator/denominator-driven to measurement and towards an activity-based approach.

CMS also welcomes comments on future timing for requiring a measure that includes EHR-PDMP integration and on the value of the measure for advancing the effective prevention and treatment of opioid use disorder especially in relation to the requirements of the SUPPORT for Patients and Communities Act described above. Specifically, CMS is interested in stakeholder comments related to potential opportunities for the Medicare Promoting Interoperability Program to take into account States' Medicaid investments and requirements.

AMIA Comments: AMIA recommends CMS work closely with ONC and its Certification Program to ensure standards are adopted by health IT to enable functionalities in support EHR-PDMP integration. We would not support inclusion of a new measure until such time when Certified health IT is tested to support the functionalities identified by CMS.

Verify Opioid Treatment Agreement Measure

CMS is proposing to remove the Verify Opioid Treatment Agreement measure from the Promoting Interoperability Program beginning with the EHR reporting period in CY 2020.

AMIA Comments: AMIA is pleased with this proposal, as well. In our comments to CMS last year, we noted the technical difficulty of this measure and the controversy stated by CMS and observed elsewhere over the efficacy of treatment agreements.

Health Information Exchange Objective: Support Electronic Referral Loops by Receiving and Incorporating Health Information

In an effort to more clearly capture the previously established policy, CMS is proposing to revise the regulations for the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. CMS is proposing that the electronic summary of care record must be received using CEHRT and that clinical information reconciliation for medication, medication allergy, and current problem list must be conducted using CEHRT.

AMIA Comments: Once again, we recommend that CMS finalize the HIE objective with separate measures: (1) Request/Accept Summary of Care and (2) Clinical Information Reconciliation, both of which are supported by 2015 Edition CEHRT and have been demonstrated in-production at scale. Questions posed by CMS regarding ways to potentially calculate this measure electronically, as well as questions over recertification, supports our view that the PI Program is not ready for the single measure proposed.

Proposed Changes to the Scoring Methodology for Eligible Hospitals and CAHs Attesting to CMS Under the Medicare Promoting Interoperability Program for an EHR Reporting Period in CY 2020

As previously discussed, CMS is proposing for CY 2020 to: (1) remove the Verify Opioid Treatment Agreement measure; (2) continue the Query of PDMP measure as optional with 5 bonus points; and (3) change the maximum points available for the e Prescribing measure to 10 points beginning in CY 2020, in the event CMS finalizes the proposed changes to the Query of PDMP measure.

AMIA Comments: As applied to our previous recommendations for PI Program measures, we still believe that the minimum composite score of 50 adequately allows room for hospitals to successfully comply, so long as each required measure requires submission of at least one in the numerator. We therefore recommend a slight revision to the points allocation (see Table 1 below):

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Table 1: CMS Proposed, AMIA Recommended PI Program Measures & Points Allocation

Objective	Measure(s)	Maximum Points (CMS proposal)	Maximum Points (AMIA recommendations)
e-Prescribing	e-Prescribing	10 points	5 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 points bonus	5 points bonus
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 points	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points	Request/Accept Summary of Care: 10 points Clinical Information Reconciliation: 10 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	40 points
Public Health and Clinical Data Exchange	Syndromic Surveillance Reporting (Required) <u>Choose one or more additional:</u> Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Electronic Reportable Laboratory Result Reporting	10 points	Syndromic Surveillance Reporting, Immunization Registry and Reportable Lab Results (Required) <u>Choose one or more additional:</u> Electronic Case Reporting, Public Health Registry Reporting; Clinical Data Registry Reporting 20 points

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Request for Information (RFI) Regarding Potential Adoption of the Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and EHR Data (Hybrid HWR Measure) for Reporting Periods Beginning with CY 2023

The Hybrid HWR measure is designed to capture all unplanned readmissions that arise from acute clinical events requiring urgent re-hospitalization within 30 days of discharge, and it provides a facility-wide picture of this aspect of care quality for Medicare fee-for-service (FFS) beneficiaries who are 65 years or older and hospitalized in non-federal hospitals. In addition, the measure reports a single summary risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of hospital discharge for any eligible condition, and indicates the hospital-level standardized readmission ratios (SRR) for each category. The discharge condition categories or procedure categories for this measure are: (1) surgery/gynecology; (2) general medicine; (3) cardiorespiratory; (4) cardiovascular; and (5) neurology.

CMS is seeking comment on whether CMS should consider proposing to adopt the Hybrid HWR CQM in future rulemaking for the Promoting Interoperability Program starting with the reporting period in CY 2023.

AMIA Comments: AMIA supports the adoption of the Hybrid HWR measure. However, we note that the proposed discharge condition/procedure categories for the measure would need specified ICD-10 diagnoses. Without these specific definitions, we would anticipate that the database would become unwieldy to manage.

Proposed CQM Reporting Periods and Criteria for the Medicare and Medicaid Promoting Interoperability Programs in CY 2020, 2021, and 2022

For CY 2020 and 2021, CMS is proposing generally the same CQM reporting periods and criteria as established in the FY 2019 IPPS/LTCH PPS final rule for the Medicare and Medicaid Promoting Interoperability Programs in CY 2019 (83 FR 41671). CMS is proposing that the CQM reporting period and criteria under the Medicare and Medicaid Promoting Interoperability Programs for eligible hospitals and CAHs reporting CQMs electronically would be as follows: for eligible hospitals and CAHs participating only in the Promoting Interoperability Program, or participating in the both Promoting Interoperability Program and the Hospital IQR Program, report one, self-selected calendar quarter of data for fits self-selected CQMs from the set of available CQMs.

AMIA Comments: AMIA supports the continuation of these reporting requirements, which will aid hospitals in their data extraction processes and provide them with flexibility as they fully implement 2015 CEHRT. We believe that this policy supports the ultimate goal of more efficient and seamless electronic collection and submission of quality measures.

Proposed CQM Reporting Periods and Criteria in CY 2022

For CY 2022, CMS is proposing that the CQM reporting period and criteria under the Medicare Promoting Interoperability Program for eligible hospitals and CAHs reporting CQMs electronically

would be as follows -- for eligible hospitals and CAHs participating only in the Promoting Interoperability Program or participating in both the Promoting Interoperability Program and in the Hospital IQR Program, report one, self-selected calendar quarter of data for: (a) three self-selected CQMs from the set of available CQMs; and (b) the proposed Safe Use of Opioids – Concurrent Prescribing CQM (NQF #3316e), for a total of fits CQMs.

AMIA Comments: AMIA supports this proposal.

Request for Information (RFI) on a Metric to Improve Efficiency of Providers within EHRs

In November 2018, ONC released the draft report "Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs," as required by section 4001 of the 21st Century Cures Act. CMS believes further adoption of more efficient workflows and technologies such as those identified in the draft report will help health care providers with overall improvements in patient care and interoperability, and CMS is seeking comment on how such implementation of such processes can be effectively measured and encouraged as part of the Promoting Interoperability Program.

AMIA Comment: As stated above, AMIA does not recommend CMS pursue numerator/denominator measures as part of the future of Promoting Interoperability. We find it especially problematic that CMS wishes to establish an efficiency metric that would likely complicate health IT usability, clinical workflows – and thus provider efficiency within EHRs – that numerator/denominator measures have caused. However, we do note that IT is evolving and provide examples of technology that could be examined and further evolved to improve provider efficiency below.

CMS Question	AMIA Response
What do stakeholders believe would be useful ways to measure the efficiency of health care processes due to the use of health IT? What are measurable outcomes demonstrating greater efficiency in costs or resource use that can be linked to the use of health IT-enabled processes? This includes measure description, numerator/denominator or "yes/no" reporting, and exclusions.	As described in "Creating Patient Centered Team-based Primary Care,"[6] high-functioning healthcare teams can deliver high-quality patient-centered care when methodologies are implemented to promote information sharing, shared decision making, care coordination, self-management, and support. Instead of searching for each health team member's notes, recommendations, and goals, EHRs have extraordinary flexibility to coalesce data into clinical summary views where all members of a patient's healthcare team can review what all other members of the patient's healthcare team are learning and contributing to promote the patient's care. Providing these interdisciplinary views of the plans of care greatly increases the efficiency of reviewing patient care requirements,

[6] Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, Genevro J. Creating Patient-Centered Team-Based Primary Care. AHRQ Pub. No. 16-0002-EF. Rockville, MD: Agency for Healthcare Research and Quality. March 2016. https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf

	helps determine appropriate continuing care plans, and effectively supports patients to successfully return to their communities. While measures to assess the efficiency of providers and healthcare organizations are no doubt important, we also note the need for measures that assess the efficiency of EHRs for patients, families, and caregivers. A primary goal of the 21st Century Cures Act is making personal health information easily accessible to patients, and measuring the efficiency of health IT for use by patients is critical to facilitating achievement of this goal. Measurable outcomes that demonstrate greater efficiency in costs or resource use may include: (1) demonstrating greater clinician efficiency; (2) reduction in length of stay; and (3) improved clinician and patient satisfaction. In lieu of measures with a numerator/denominator, we recommend allowing hospitals to attest that they are engaged in activities that seek to mitigate inefficiencies in these areas.
What are specific technologies, capabilities, or system features (beyond those currently addressed in the Promoting Interoperability Program) that can increase the efficiency of health care provider interactions with technology systems, for instance, alternate authentication technologies that can simplify health care provider logon? How could CMS reward health care providers for adoption and use of these technologies?	AMIA supports incentive programs that would create new and efficient methods to streamline the prior authorization process and ordering drugs and equipment. This would include collaborative efforts with payers, equipment suppliers, and EHR vendors, all being cognizant of that the fact that services and equipment can vary in a highly individualized way. Natural Language Processing (NLP) has advanced to a great degree, where systems can now provide, in real-time, ICD-10 / SNOMED coded diagnoses. Machine Learning (ML) and AI algorithms can then be applied to these diagnoses to provide real-time clinical decision support guiding clinicians to evidence-based

	care guidelines then achieve greater adherence to standards with significantly improved patient outcomes with improved safety, reduced morbidity, enhanced satisfaction, and reduced costs. The CMS Innovation Center could provide funding to further investigate the many ways NLP, ML, and AI can be used to provide evidence-based clinical decision support (CDS) for healthcare providers and healthcare systems.
What are key administrative processes that could benefit from more efficient electronic workflows, for instance, conducting prior authorization requests? How could CMS measure and reward health care providers for uptake of more efficient electronic workflows?	Robotic Process Automation (RPA) uses a "robot" to integrate actions from EHRs to execute a business process. RPA bots can log into EHR, connect to system APIs, copy and paste data, move file and folders, extract and process structured and semi-structured content from documents, PDFs and forms, then write to databases. This technology has tremendous value automating reports such as prior authorization. Using RPA would eliminate clinician time, improve efficiency, and enhance satisfaction for all engaged parties; e.g., physicians, clerical staff, patients, and insurance agencies. Once again, the CMS Innovation Center could provide funding to further investigate the potential applications of RPA to healthcare providers and healthcare systems.

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Request for Information (RFI) on Including Medicare Promoting Interoperability Program Data on the Hospital Compare Website

As the Medicare Promoting Interoperability Program continues to evolve, CMS is seeking comment on posting Medicare Promoting Interoperability Program measure(s) on the Hospital Compare website. As CMS considers posting information regarding the Medicare Promoting Interoperability Program measures in the future, CMS is seeking comment on the following:

CMS Question	AMIA Response
Of the six required measures and one bonus measure that would apply for an EHR reporting period in CY 2020, how many and which ones should CMS consider posting?	At a minimum, Hospital Compare should include PI Program data related to the following measures: eRx; Provide Patients Electronic Access to Their Health Information; and the kinds of public health and clinical data exchange they engage.
What process should be in place to allow eligible hospitals and CAHs the opportunity to review the data prior to publication? This includes comment on how many days the preview period should be for eligible hospitals and CAHs to review data prior to publication and a correction process for those who may have identified an error in their data.	CMS already makes use of Qualified Clinical Data Registries (QCDR) and Qualified Registries (QR) that are authorized to submit quality measures, PI Program measures, and improvement activities on behalf of MIPS eligible clinicians, groups, virtual groups, and hospitals. The QCDR and QR compile then submit the quality data on behalf of the eligible hospitals. We recommend that the QCDRs and QRs provide their clients (hospitals and CAHs) a 6-week review period prior to publication to provide a correction process for those who have identified errors in their data.
CMS is seeking comment on posting the data on its Hospital Compare website, found at: www.medicare.gov/hospitalcompare.	AMIA places tremendous value in performance transparency. As such, we would like to see CMS release all appropriate administrative data related to the PI Program, not simply a grade – or worse – a binary "pass/fail," score. Public expenditures belong to the citizens of the US, and CMS should strive to ensure the utmost transparency around cost, quality, and performance.

Request for Information (RFI) on the Provider to Patient Exchange Objective

Recognizing the importance of patients having access to their complete health information, including clinical information from the eligible hospital or CAH's CEHRT, and appreciating the new technical flexibility a standards-based API provides, CMS is seeking comment on whether eligible hospitals and CAHs should make patient health information available immediately through the open, standards-based API,

no later than one business day after it is available to the eligible hospital or CAH in their CEHRT. CMS is also seeking comment on the barriers to more immediate access to patient information. And, CMS is seeking comment on if there are specific data elements that may be more or less feasible to share no later than one business day.

The existing Provide Patients Electronic Access to Their Health Information measure does not specify the overall operational expectations associated with enabling patients' access to their health information. For instance, the measure only specifies that access must be "timely." As a result, CMS is requesting public comment on whether they should revise the measure to be more specific with respect to the experience patients should have regarding their access. For instance, in the ONC 21st Century Cures Act proposed rule (84 FR 7481 through 7484) there is a proposal regarding requirements around persistent access to APIs, which would accommodate a patient's routine access to their health information without needing to reauthorize their app and re-authenticate themselves. CMS is seeking comment on whether the Promoting Interoperability Program measure should be updated to reinforce this proposed technical requirement for persistent access.

AMIA Comment: CMS should strive to align ONC-developed functional requirements with its own programmatic policies whenever possible. For instance, were ONC to finalize its policy for persistent access for (g)(10)-certified APIs, CMS should ensure its policies reflect an expectation that certified health IT be used in such a way. We recommend that CMS (1) modify the existing Provide Patients Electronic Access to the Health Information measure to reference ONC's USCDI and (2) establish in this measure a requirement that such access is to be persistent. Patient data added to an existing record should be available within the existing 36-hour requirement.[7]

CMS is specifically seeking public comment on the following question: if ONC's proposal for a FHIR-based API certification criteria is finalized, would stakeholders support a possible bonus under the Promoting Interoperability Programs for early adoption of a certified FHIR-based API in the intermediate time before ONC's final rule's compliance date for implementation of a FHIR standard for certified APIs?

AMIA Comment: Yes, CMS should use its policy levers to encourage adoption in program year 2020. In addition, AMIA recommends CMS establish the timeline – not ONC – for provider adoption of certified health IT. Please see our ONC comments for more.[8]

[7] Medicare Promoting Interoperability Program Stage 3 Eligible Hospitals, Critical Access Hospitals, and Dual-Eligible Hospitals Attesting to CMS Objectives and Measures for 2018. See page 3 at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicareEHStage3_Obj3.pdf#page=3

[8] See page 11. AMIA Response to ONC 21st Century Cures Act NPRM. Available at: https://www.amia.org/sites/default/files/AMIA-Response-to%20-ONC-Cures-NPRM.pdf#page=11

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Building on proposals from the ONC Cures and CMS Interoperability and Patient Access proposed rules, CMS is seeking comment on an alternative measure under the Provider to Patient Exchange objective that would require health care providers to use technology certified to the EHI criteria to provide the patient(s) their complete electronic health data contained within an EHR. Specifically, CMS is seeking comment on the following questions:

CMS Question	AMIA Response
Do stakeholders believe that incorporating this alternative measure into the Provider to Patient Exchange objective will be effective in encouraging the availability of all data stored in health IT systems?	We support inclusion of a measure as a bonus option, rather than an alternative measure for the Provider to Patient Exchange objective. It is doubtful that many hospitals will have this capability in program year 2020, but a bonus option may encourage adoption.
In relation to the Provider to Patient Exchange objective as a whole, how should a measure focused on using the proposed total EHI export function in CEHRT be scored?	We recommend CMS consider this measure as a bonus for the objective, rather than an alternative.
If this certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure? Should this measure be established as an attestation measure?	After CMS establishes a deployment deadline for all hospitals to have this capability deployed, AMIA recommends that it should be established as an attestation measure.
In the long term, how do stakeholders believe such an alternative measure would impact burden?	Ultimately, we hope that most provider burden related to delivering patient access requests would be removed, if not greatly diminished. There will remain a new need in helping patients understand and interpret data accessed via EHI export, but the challenge of providing access via provider intermediaries should no longer exist. However, we anticipate that this functionality will require much more refinement and stakeholder engagement to maximize its potential.
What data elements do stakeholders believes are of greatest clinical value or would be of most use to health care providers to share in a	Likely, the data contained within the USCDI will prove of immediate need, but there is a growing list of data types and reports (especially around new genomics and diagnostic testing, mHealth, and wearables) that will also be important.

standardized electronic format if the complete record was not immediately available?	

In addition to the above questions, CMS have some general questions that are related to health IT activities, for which CMS is also seeking public comment:

CMS Question	AMIA Response
Do stakeholders believes that CMS should consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long term care, behavioral health, and home and community-based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should CMS consider when implementing a health information exchange across the care continuum health IT activity in the Promoting Interoperability Program?	AMIA enthusiastically supports such a health IT activity. Bi-directional exchange of health information across the care continuum is obligatory at this stage in the evolution of health information and community partners. However, AMIA also strongly encourages CMS to add to the list of post-acute care, long term care, behavioral health and home and community-based services the patient's healthcare insurance plan. While all insurance plans require a pre-admission / pre-procedure authorization to approve the delivery of care, there is no insurance plan engagement with the patient's care coordination once discharged from the hospital back into the community. Engaging the patient's insurance plan to become more actively involved in managing the post-hospitalization care coordination will promote a greater understanding of the patient's expected care requirements and the related costs for that care. Health IT activities that support bi-directional exchange of health information with community partners are imperative for the overall success of the effort. Increasing use of mobile health devices and apps, remote sensors, and other technologies in development, are making it possible for patients to receive more care and services at home, and the shift to a less facility-centric model requires bi-directional data flow to ensure that providers can adequately manage patients' needs. Greater acceptance of and reimbursement for telemedicine, as well as growing delivery of health-related services in nontraditional environments (e.g., physical therapy/exercise at senior centers), support use cases based upon bi-directional data flow; CMS policy and requirements should do so as well.
What criteria should CMS employ, such as specific goals or areas of focus, to identify high	As part of our continued recommendations that CMS move towards accepting hospital-submitted Inpatient Improvement Activities (IIAs), we recommend that CMS

priority health IT activities for the future of the program?	look towards current large-scale national quality improvement initiatives, or priorities, such as VTE, Sepsis, Readmission Risk, SBIRT, or medication adherence as part of its potential focus. CMS should additionally consider broad priority areas for hospitals to focus: such as patient engagement, promoting interoperability, patient safety and clinical quality improvement. Another way CMS may orient the future of the program is to move from an illness and disease paradigm to a wellness and health paradigm. The current Medicare Diabetes Prevention Program[9] provides a framework for this concept. The primary goal of the program is to achieve a 5 percent weight loss by participants. This is just one example. Smoking Cessation, Alcohol Consumption, Hypertension Medication Management Adherence are just a few additional programs where engaging the individual to be rewarded for their success will promote health, well-being, and significantly reduce the cost of care for these illnesses and diseases.
Are there additional health IT activities CMS should consider recognizing in lieu of reporting on existing measures and objectives that would most effectively advance priorities for nationwide interoperability and spur innovation?	Indeed, as we have stated, rather than increase the number/kinds of required measures, we recommend CMS evolve the PI Program to decrease the number of measures by tolerating, and eventually encouraging, hospital-developed IIAs that leverage CEHRT - as well as functionality that leverages CEHRT (e.g. APIs). In place of measures, CMS should require hospitals to (1) adhere to CEHRT updates and attest that have all the functionalities of CEHRT are "turned on" and (2) Adopt/upgrade to new CEHRT within a reasonable period, not to exceed 18-months, for deployment. The public health sector is especially ripe for additional health IT activities CMS should consider recognizing. The sector relies upon a wide range of EHRs that are not currently fully interoperable with the private sector. Consider the Management of Tuberculosis[10] where "Directly Observed Treatment (DOT)" is a mainstay of therapy. This well-documented care requirement places a tremendous burden on State, County, and Community health departments and providers. Imagine the costs associated with

[9] https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/
[10] https://www.cdc.gov/tb/publications/guidelines/pdf/clin-infect-dis.-2016-nahid-cid_ciw376.pdf

	providing vehicle transportation – including gas, mileage, and wear and tear – for healthcare providers to visit patients' homes, community shelters, and prisons to directly observe a patient taking their prescribed medication. Using telemedicine can tremendously reduce the costs and significantly improve care of these individuals. In another example, State TB Registries collect a tremendous amount of data when tracking an individual's treatment therapies and adhering to requirements to coordinate an individual's movement between states, counties, and into or out-of-state. They also manage the legal interventions required when an individual is not compliant with their treatment interventions. AMIA recommends that CMS evaluate effective priorities for nationwide interoperability between the public and private health sector to enhance coordination of care activities, reduce physician and administrative burden, and best manage the cost of public health services.

Patient Matching

Recognizing Congress' statement regarding patient matching and stakeholder comments stating that a patient matching solution would accomplish the goals of a UPI, CMS is seeking comment for future consideration on ways for ONC and CMS to continue to facilitate private sector efforts on a workable and scalable patient matching strategy so that the lack of a specific UPI does not impede the free flow of information. CMS is also seeking comment on how CMS may leverage its program authority to provide support to those working to improve patient matching. CMS notes that it intends to use comments it receives for the development of policy and future rulemaking.

AMIA Comments: AMIA reiterates its comments[11] on patient matching that it submitted in response to CMS' Interoperability and Patient Access NPRM.

Request for Information (RFI) on Integration of Patient-Generated Health Data into EHRs Using CEHRT

[11] https://www.amia.org/sites/default/files/AMIA-Response-to-CMS-Interop-and-Patient-Access-NPRM.pdf

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The Medicare and Medicaid Promoting Interoperability Programs are continuously seeking ways to prioritize the advanced use of CEHRT functionalities, encourage movement away from paper-based processes that increase heath care provider burden, and empower individual beneficiaries to take a more impactful role in managing their health to achieve their goals. CMS is interested in ways that the Promoting Interoperability Program could adopt new elements related to PGHD that: (1) represent clearly defined uses of health IT; (2) are linked to positive outcomes for patients; and (3) advance the capture, use, and sharing of PGHD. In considering how the Promoting Interoperability Program could continue to advance the use of PGHD, CMS also notes that a future program element related to PGHD would not necessarily need to be implemented as a traditional measure requiring reporting of a numerator and denominator. For instance, in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20538), CMS requested comment on the concept of "health IT" or "interoperability" activities to which a health care provider could attest, potentially in lieu of reporting on measures associated with certain objectives. By addressing the use of PGHD through such a concept, rather than traditional measure reporting, CMS could potentially reduce the reporting burden associated with a new PGHD-related program element. CMS is inviting stakeholder comment on these concepts, and the specific questions below:

CMS Question	AMIA Response
What specific use cases for capture of PGHD as part of treatment and care coordination across clinical conditions and care settings are most promising for improving patient outcomes? For instance, use of PGHD for capturing advanced directives and pre/post-operation instructions in surgery units.	As noted in the above reference to the Medicare Diabetes Prevention Program, there is an opportunity to consider ways to incentivize clinicians and beneficiaries to be actively engaged in their own health and wellbeing. The Pew Research Center reports[12] that a vast majority of Americans (96%) now own a cellphone of some kind. Having wellness and health apps, connected through APIs to their physician EHRs, would allow patients to record, monitor, and see their progress towards meeting the goals set by their physician providers. PGHD could include activities such as (1) healthy eating, (2) being active, (3) monitoring weigh, blood pressure, or blood glucose, (4) taking medications, (5) problem solving, (6) healthy coping, and (7) reducing risk. Engaging providers, vendors, and individuals to develop mobile phone, laptop /tablet / computer applications to monitor, then report on these seven categories would promote

[12] https://www.pewinternet.org/fact-sheet/mobile/

	greater health and wellness, while reducing the cost to managing disease and injuries. Other impactful use cases that merit further study and development include capture of advance directives, elder fall reduction and safety in the home, medication monitoring and management of children during school and related activities, patient-reported outcome data creation and submission, and medication refill ordering.
Should the Promoting Interoperability Program explore ways to include bonus points for health care providers engaging in activities that pilot promising technical solutions or approaches for capturing PGHD and incorporating it into CEHRT using standards-based approaches?	AMIA strongly supports care providers becoming engaged with activities that pilot technical solutions or approaches for capturing PGHD then incorporating into their CEHRT.
Should inpatient health care providers be expected to collect information from their patients outside of scheduled appointments or procedures? What are the benefits and concerns about doing so?	Providers should be expected to collect information from their patients outside of scheduled appointment or procedures, if the data that is being collected is well-defined and fits into a patient's plan of care and coordination. Recognizing the numerous evidence-based guidelines by well-established professional societies and identifying the key components of patient collected data in a systematic, well-defined and structured manner, will add tremendous value to a clinician's ability to provide care and services to their patient's. Without a coordinated effort to define the PGHD, then our clinicians are at risk of obtaining discordant, unreliable data that becomes difficult to interpret, analyze, or act upon in a credible manner.
Should the Promoting Interoperability Program explore ways to reward health care providers for implementing best practices associated with optimizing clinical workflows for obtaining, reviewing, and analyzing PGHD?	Yes, but as described above, this could be a goal for IIAs.

Request for Information (RFI) on Engaging in Activities that Promote the Safety of the EHR

As CMS continues to advance the use of CEHRT in health care, CMS is seeking comment on how to further mitigate the specific safety risks that may arise from technology implementation. Specifically, CMS is seeking comment on ways that the Promoting Interoperability Program may reward hospitals for engaging in activities that can help to reduce errors associated with EHR implementation.

Specifically, CMS might consider offering points towards the Promoting Interoperability Program score to hospitals that attest to conducting an assessment based on the High Priority Practices and/or the Organizational Responsibilities SAFER Guides which cover many foundational concepts from across the guides. Alternatively CMS might consider awarding points for review of all nine of the SAFER Guides. CMS is also inviting comments on alternatives to the SAFER Guides, including appropriate assessments related to patient safety, which should also be considered as part of any future bonus option. CMS is requesting comment on the ideas above, as well as inviting stakeholders to suggest other approaches CMS might take to rewarding activities that promote reduction of safety risks associated with EHR implementation as part of the Promoting Interoperability Program.

AMIA Comments: AMIA supports CMS efforts to understand and address patient safety issues that may arise due to use of health IT. We specifically support CMS efforts to promote the SAFER Guides and policies to incentivize providers to use them. The same notion of incentive should apply to improving providers' cyber hygiene, in addition to health IT safety posture. We reiterate our view that CMS should abandon the construct of measure reporting in favor of an activity-based approach, which would enable organizations to demonstrate clinically meaningful use of health IT for their specific patient populations and priorities, without forcing novel enactment strategies. The approach we envisioned would replace functional measures prescribed by CMS with clinically-relevant Inpatient

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Improvement Activities (IIAs), according to both local/regional priority and HHS strategy. We are thus pleased that CMS is considering an activity-based approach to addressing patient safety issues that arise from the use of EHR.

AMIA believes that health IT safety is a responsibility shared among developers, healthcare organizations, clinicians, patients and government stakeholders. However, while certain patient safety risks are pervasive across the health sector, others are unique to different providers and healthcare organizations. We recommend applying our approach to IIAs to EHR safety activities, in that healthcare organizations should receive PI Program credit for leveraging their unique EHR safety activities and/or procedures. While we had originally recommended that CMS encourage CMMI to initiate pilots to better understand what systems and controls are needed to support an IIA program, we see the area of EHR safety as a good opportunity to test this concept, as well.