August 12, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
Submitted electronically http://www.regulations.gov

Re: Request for Information; Reducing Administrative Burden to put Patients over Paperwork

Dear Administrator Verma,

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on this Request for Information (RFI) for advancing CMS' efforts to put Patients over Paperwork.

Informatics is the science of how to use data, information, and knowledge to improve human health and the delivery of health care services. AMIA is the professional home for more than 5,500 informatics professionals, representing frontline clinicians, researchers, public health experts, and educators who bring meaning to data, manage information, and generate new knowledge across the research and healthcare enterprise. AMIA members advance health and wellness by implementing and evaluating informatics interventions, innovations, and public policy across settings and patient populations, adding to our collective understanding of digital health through peer-reviewed journals and scientific meetings.

While we support the Patients Over Paperwork initiative and appreciate the multi-pronged approach CMS has taken to address administrative and regulatory burdens, we urge CMS to consider how its programs and policies should evolve, now that electronic health records (EHRs) and other health IT are ubiquitous. The very nature of paperwork has changed with the widespread adoption of EHRs. This shift to digital data from paper records creates a tremendous opportunity to revisit the primary drivers of burden, including regulatory compliance, fraud prevention, and cost containment.

AMIA strongly supported the draft "HHS Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs."[1] In our response, we called on CMS to establish a "long-term goal of decoupling clinical documentation from billing, regulatory, and administrative compliance requirements," adding, "We have a tremendous opportunity to leverage informatics tools and methodologies to decouple clinical documentation from billing and better

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[1] https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs

integrate regulatory compliance requirements into clinician workflow so that clinical decision support (CDS) and quality/performance reporting are better positioned to improve care for patients and reduce burden for clinicians."[2] We noted that, "Numerous informatics tools and methodologies are being leveraged to more easily capture clinical data and represent intensifying quantities of data at the point-of-care. Natural language processing, remote sensing, video capture, and data mining are improving, yet these improvements only impact administrative burdens of EHRs at the margins."[3] AMIA encourages CMS to finalize this Strategy and use it as a central vehicle to better position patients over paperwork.

Some drivers of burden, such as documentation requirements, are rooted in a paper-based paradigm. For many burdens in these categories, the implementation of health IT simply replicated our paper processes and it has magnified and modified pre-existing burdens and challenges. For other burdens, such as quality reporting and Promoting Interoperability Program requirements, policymakers have sought to implement policy through health IT, rather than position health IT to facilitate progress / action towards fulfilling the policy goal. In these instances, health IT becomes the end unto itself, and the policy goals (e.g. smoking cessation, blood pressure control, or reduced medication error) become obfuscated by numerator/denominator-driven dashboards.

Recommendations to address several categories of burden are below:

Documentation

- As stated above, CMS should articulate a long-term goal of decoupling clinical documentation from billing, regulatory, and administrative compliance requirements. The ubiquity of EHR use/implementation/availability additionally makes it unnecessary that all documentation be stated more than once in a clinical note.
- AMIA recommends more funding from ONC, the National Library of Medicine (NLM), and the Agency for Healthcare Research and Quality (AHRQ) be dedicated to documentation-related R&D, including the use of image/video-, voice-, and sensor-derived data for clinical and other documentation.
- AMIA recommends CMS convene specialty societies to develop documentation guidelines and that these organizations work with informatics and health IT professionals. Dedicated and sustained funding should be devoted to this work. with the goal of minimizing requirements for documentation and identifying ways to support pulling the data needed by health plans, including Medicare, from the existing data without burdensome documentation requirements.

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[2] https://www.amia.org/sites/default/files/AMIA-Response-to-ONC-HIT-Burden-Reduction-Strategy_0.pdf

[3] Ibid.

- We should migrate our health plan oversight processes to a 21st century digital paradigm that benefits from our multi-billion dollar investment in digital technology. Software can be very successful at this task. CMS should work with stakeholders to develop the policies, standards, and infrastructure to migrate this clerical job from humans to computers.

Reporting

- Allowing clinicians/hospitals to selectively define and report quality measures of their choosing fails to achieve a national consensus focus on clinical conditions that inflict greatest burden on patients, most serious morbidity and mortality, and heaviest costs. AMIA recommends that CMS identify activities and desired outcomes associated with high morbidity/cost conditions and focus its metric developments around them, taking account of the ample range of evidence generated by outcomes and other research in recent years. Such a focused set of metrics would more meaningfully enable all clinicians to focus on national priorities. Patient/problem/condition-focused documentation would capture metric value-set elements as by-products of clinical care, more rapidly enabling the transition from existing EHR data to eCQMs.

Program Alignment

- Current lack of alignment across government/private payer programs results in a plethora of metrics expected from clinicians causing excessive and redundant documentation, confusion regarding clinical goals and measures, and adversely impacts both clinical care and provider well-being. The excessive documentation compounds the challenges of burden by making it more difficult to identify the clinical relevance of the data. Thus, efforts CMS has undertaken to reduce misalignment across federal programs are laudable.

  In the recently-released Proposed Medicare Physician Fee Schedule for calendar year 2020, CMS is soliciting comment on Medicare Shared Savings Quality Performance Scoring Methodology alignment with MIPS scoring. AMIA notes other alignment challenges include Medicare-Medicaid, CMS-other payers, and Hospital-provider. We recommend that CMS look to further mitigate these challenges, including incentivizing private payers to adopt similar goals and measures, to the extent possible.

  Finally, we note that regulatory burden is compounded by a number of other requirements under State regulation, private payers, and accrediting organizations (including state accreditations). Layer on specialty certification i.e. stroke certified, chest pain certified, baby friendly hospital, etc. adds a tremendous amount of duplicity and reporting burden for the resources to support all of it.

- In 2016, CMS contracted with the National Quality Forum to convene a "Core Measure Quality Collaborative" which is currently in its second cycle of recommendations. This

partnership between CMS, private payers, and measure developers agreed on a core set of quality measures for specific specialties. While we are supportive of this effort, it has unfortunately not received the support it needs to be successful. We recommend CMS revisit this initiative to ensure a stronger commitment from all regulatory/private payers in order to help it succeed.

Health IT Usability and the User Experience

- CMS should require the use of Certified Health IT and work with ONC so that its Certification Program more explicitly requires a national universal set of standards for EHR symbols, shapes, and colors for ancillary service reporting and medication labeling nomenclature.

Other Regulatory Compliance

- Payers continue to increase requirements for prior authorization, which could be provided as bundled data from the EHR. We recommend CMS expand appropriate use criteria, while defining data requirements for prior authorization.
- Updating and streamlining CMS Conditions of Participation (CoP) and State Operating Manual (SOM) guidelines, rules and regulations would provide relief from the tremendous burdens encumbered by the current processes utilized today.

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