



September 13, 2021

The Honorable Chiquita Brooks-LaSure  
Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1751-P  
Submitted electronically <http://www.regulations.gov>

Re: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the CY2022 Physician Fee Schedule 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' continued efforts to reimburse mental health providers for providing specified telehealth and other services that utilize communications technology. We are especially appreciative of the balance between access, patient safety, and clinical appropriateness that CMS has sought to strike in its proposals.

AMIA also continues to support the goals of the MIPS Value Pathways (MVP) framework to align and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities categories. However, as we detail below, we believe that CMS is missing a prime opportunity to fully transform MIPS by centering use of certified health IT.

Finally, we strongly support – with additions also detailed below – CMS' proposal to require reporting of the Immunization Registry Reporting and Electronic Case Reporting measures beginning with the performance period in CY 2022 in the current incarnation of MIPS. The COVID-19 public health emergency has shown a bright light on the deficiencies of our nation's public health infrastructure. As long-time proponents of proposals to emphasize public health

September 13, 2021

reporting in Promoting Interoperability, we view this proposal as an excellent step toward improving real-time, electronic data exchange from providers to public health agencies.

Below are detailed comments in response to selected proposals and request for information. 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 Scott Weinberg, Public Policy Specialist at [scott@amia.org](mailto:scott@amia.org) or (240) 479-2134. We look forward to continued partnership and dialogue.

Sincerely,



Patricia C. Dykes, PhD, RN, FAAN, FACMI  
AMIA President and Chair, AMIA Board of Directors  
Program Director Research  
Center for Patient Safety, Research, and Practice  
Brigham and Women's Hospital

*(Enclosed: Detailed AMIA Comments regarding CMS' CY22 PFS NPRM)*

## Telehealth and Other Services Involving Communications Technology

CMS is proposing to require an in-person, non-telehealth service be provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service, and at least once every six months thereafter. It is also proposing to amend the current regulatory requirement for interactive telecommunications systems – which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner – to include audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes.

CMS is further proposing to limit the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology.

**AMIA Comments:** AMIA applauds CMS for continuing to recognize the increased digitization of healthcare delivery – made even more apparent by the COVID-19 pandemic – and proposing to solidify reimbursement where it can. We view these policies as addressing long-standing Medicare reimbursement barriers to widespread adoption of virtual care tools meant to reach more patients in more places, especially those in underserved and rural areas.

Health IT should always serve to enhance clinical effectiveness and patient safety, so we are pleased that CMS recognizes that the question of whether or not audio-only interactions are clinically appropriate is specialty-dependent, and the clinical effectiveness of virtual care may be affected as a result. We thus support the “carve-out” for reimbursing mental health telehealth services furnished via audio-only. We additionally support requiring an in-person evaluation within six months prior to the initial telehealth service, as we believe that telehealth clinical effectiveness and patient safety are only enhanced when there is an already established patient-provider relationship.

We further support, with one caveat, the proposal to limit the use of an audio-only interactive telecommunications system in instances where a patient is not capable of using, or does not consent to, the use of two-way, audio/video technology. A CMS-prescribed addition of live-video for a psychiatric visit would not only be unnecessary for some patients, but it could also make such services less accessible to older individuals or individuals without smartphones or computers at home. It is often these individuals where care coordination and check-ins are most important. CMS should clarify, however, that a mental health provider should be able to bill for an audio-only visit if they feel that the use of video would be clinically unnecessary.

Finally, AMIA cautions that while patients, especially those in underserved areas, may see benefits from these telehealth services, we run the risk of creating more health IT data silos in the care continuum as telehealth applications continue to proliferate. To the greatest extent possible, the

September 13, 2021

provider's audio/video communications systems should be integrated into their existing health IT or EHR, if applicable.

### **Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs – Request for Information**

CMS aims to move fully to digital quality measurement by 2025. They also continue to evolve the Medicare Promoting Interoperability Program's focus on the use of certified electronic health record (EHR) technology, from an initial focus on electronic data capture to enhancing information exchange and expanding quality measurement. However, reporting data for quality measurement via EHRs remains burdensome, and its current approach to quality measurement does not readily incorporate emerging data sources such as patient-reported outcomes (PRO) and patient-generated health data (PGHD).

**AMIA Comments:** We appreciate CMS's ambitious goal of moving to full digital quality measurement by 2025. CMS rightly notes that the Promoting Interoperability Program's focus should be the use of certified electronic health record (EHR) technology to improve patient outcomes, rather than measurement of the use of the technology. Further, we are pleased that CMS seeks to promote the standardized aggregation of patient level data across multiple health care systems for quality improvement.

We reiterate our position that CMS phase out required numerator/denominator-driven measurement through the Promoting Interoperability Program. However, if CMS intends to move towards a FHIR-based electronic measure construct, then we recommend that that it augment and enable such digital quality measurement by permitting focused activity-based approaches (as we specify below) that place emphasis on data necessary to construct the new measures. We believe that it would be a mistake to continue designing technology exclusively according to the imperative of capturing a numerator and denominator for tasks as varied and complex as clinical care. Aside from a bevy of analyses comparing functionalities across settings and geographies, it is not clear what actionable insights have been derived from much of the MU administrative data. The threshold parameters enabled by a numerator/denominator compliance schema created dozens of fluctuating requirements leading to short-term workarounds and administrative burden.

Further, we note another issue with numerator/denominator-driven measurement is how to score a given institution if the only data available is artifactual patient data left behind from multiple contacts with several disparate health care systems.

We believe that an activity-based approach will enable organizations to demonstrate clinically meaningful use of health IT for their specific patient populations and priorities without forcing novel enactment strategies. This approach should replace functional measures prescribed by CMS with clinically-relevant Inpatient Improvement Activities (IIAs) according to both local/regional priority and HHS strategy. IIAs would be similar to MIPS Improvement Activities for eligible

September 13, 2021

clinicians, yet scaled appropriately – in size, complexity, and impact – for inpatient settings. Ideally, these IIAs would:

- Require the most recent Edition of Certified EHR Technology (CEHRT);
- Align with a small number of broad strategic priorities established by HHS;
- Be hospital-developed with a description of expected data inputs, processing, and action steps, with an assessment of impact;
- Align with the patient care activities of hospitals’ credentialed and admitting physicians, who may also participate in MIPS;
- Involve a high percentage of all clinicians that care or patients in facility; and
- Be posted publicly for purposes of transparency

### Definition of Digital Quality Measures

CMS previously noted dQMs use “sources of health information that are captured and can be transmitted electronically and via interoperable systems.” In this RFI, they seek input on future elaboration that would define a dQM as a software that processes digital data to produce a measure score or measure scores. They also note that dQMs are intended to improve the patient experience including quality of care, improve the health of populations, and/or reduce costs.

CMS also seeks feedback on how leveraging advances in technology (for example, FHIR APIs) to access and electronically transmit interoperable data for dQMs could reinforce other activities to support quality measurement and improvement.

<p>Do you have feedback on the dQM definition?</p>	<p>We request clarification on whether CMS intends to develop its own software to perform measure calculations. If so, then we believe that defining dQMs as “a software that processes digital data” will cause confusion among stakeholders, when the results of such software are what is primarily desirable. We recommend a separate definition of “dQM software” and a new definition of dQMs as, “measures that emphasize the use of data available in EHRs, gathered in the routine process of care.”</p> <p>We note that data from other health IT systems may still be required to augment EHR data. Further, data used to compile quality measures should be able to be queried in its native environment in a computable and semantically interoperable fashion. We thus affirm that access to multiple data sources, rapid cycle</p>
--	---

September 13, 2021

	<p>feedback allowing data from non-local sources to inform local clinical decision support and population health care gap identification, and alignment of programmatic requirements across all actors generating, acquiring, or hosting personal health information, will better support outcome measurement and improvement.</p>
<p>Does this approach to defining and deploying dQMs to interface with FHIR-based APIs seem promising? We also welcome more specific comments on the attributes or functions to support such an approach of deploying dQMs.</p>	<p>While we believe that FHIR-based APIs are promising, CMS should be aware that not all quality measures are available via FHIR. True quality measures, as opposed to measures that are easy to capture but only measure a small aspect of quality such as immunization status, are not currently all available through FHIR. FHIR-based data management, access, and interoperability should be seen as evolutionary, augmenting and improving the extensive and complex legacy data infrastructures implemented across every aspect of healthcare today. Presently, CMS's quality and outcome improvement programmatic objectives cannot be supported by FHIR alone.</p>

### Use of FHIR for Current eCQMs

<p>Do you agree that a transition to FHIR-based quality reporting can reduce burden on health IT vendors and providers?</p>	<p>Yes, we believe that transition to FHIR-based quality reporting, resulting in standardized elements and data representation and automated data extraction, will reduce complexity and associated vendor and provider burden.</p>
<p>Would access to near real-time quality measure scores benefit your practice?</p>	<p>Yes, consistent with our proposed definition of dQMs above, we believe that it is not enough that a measure be deemed clinically appropriate for endorsement, but the measure also be demonstrably implementable in the clinical setting, balancing value with provider time required during visits, so that the measure can be collected, reported, and submitted automatically. Most importantly, however, near real-time quality measure scores are not as useful as real-time access to interoperable data made accessible to clinical decision support infrastructures.</p>

September 13, 2021

<p>What parts of the current CMS QRDA IGs cause the most burden?</p>	<p>What causes the most burden is anything that requires work beyond what providers do to take care of patients. For example, providers can review and add a new problem list entry or medication, but unless they click “Problem list reviewed” in their EHR, they continue to see prompts to do so. Annual reviews and mapping of value set elements to local vocabularies adds to the burden, as well.</p>
<p>What could we include in a CMS FHIR Reporting IG to reduce burden on providers and vendors?</p>	<p>The Reporting IGs have become lengthy and complex. CMS should make efforts to improve clarity and reduce complexity. However, any such IG would be dependent on the definition of “quality” for the specific site. This is another reason we believe that eligible hospitals and CAHs should have such leeway by having the option to report IIAs, and that CMS should ideally chart a course towards this participation framework in the long term.</p>
<p>Do you agree that a transition to FHIR-based quality reporting can reduce burden on health IT vendors and providers?</p>	<p>Limiting quality measure to FHIR elements could accomplish alignment. To the extent FHIR resources have been defined, data are then available for either function. Clinical concepts and observations are extremely nuanced and FHIR is still evolving to better capture that nuance. Thus, exclusive use of FHIR may impose limitations on data availability. This is why believe that CMS should permit eligible hospitals and CAHs the option to report IIAs.</p>

**Changes Under Consideration to Advance Digital Quality Measurement: Actions in Four Areas to Transition to Digital Quality Measures by 2025.**

CMS is considering further modernization of the quality measurement enterprise in four major ways: (1) Leverage and advance standards for digital data and obtain all EHR data required for quality measures via provider FHIR-based APIs; (2) redesign its quality measures to be self-contained tools; (3) better support data aggregation; and (4) work to align measure requirements across our reporting programs, other Federal programs and agencies, and the private sector where appropriate.

**AMIA Comments:** If CMS proceeds with this framework, then we recommend it consider a preceding requirement, in that data captured as a by-product of clinical processes needs to be represented in accordance with FHIR standards. This would then make CMS’s remaining aims possible. CMS has already expressed such a data capture precedent in its current definition of dQM

September 13, 2021

as data “originating from sources of health information that are captured and can be transmitted electronically via interoperable systems.” We note that this may be too limiting to be able to understand and improve some important clinical outcomes.

### **Leveraging and Advancing Standards for Digital Data and Obtaining all EHR Data Required for Quality Measures via Provider FHIR-based APIs**

How important is a data standardization approach that also supports inclusion of PGHD and other currently non-standardized data?	This would be a highly desirable goal, so as to be able to automate the inclusion of such data.
What are possible approaches for testing data quality and validity?	Synthetic patient records, such as those generated through Cypress <sup>1</sup> should be evolved for FHIR-based data. A standard dataset would be captured via usual clinical workflows and then demonstrated to be extracted via the relevant FHIR API.

### **Redesigning Quality Measures to be Self-Contained Tools**

CMS is considering approaches for including quality measures that take advantage of standardized data and interoperability requirements that have expanded flexibility and functionality compared to CMS’ current eCQMs. It is considering defining and developing dQM software as end-to-end measure calculation solutions that retrieve data from primarily FHIR-based resources maintained by providers, payers, CMS, and others; calculate measure score(s), and produce reports.

How would this more open, agile strategy for end-to-end measure calculation facilitate broader engagement in quality measure development, the use of tools developed for measurement for local quality improvement, and/or the application of quality tools for related purposes such as public health or research?	This strategy would make the analytic results (“measure components”) – either at an individual patient level or in aggregate – available locally in real time so as to inform care, enable identification of care gaps, and be available electronically to clinical decision support infrastructures. We believe that public health reporting and research should similarly benefit.
Do you have feedback on policy considerations for aggregation of data from multiple sources being used to inform measurement?	CMS and ONC should leverage Certification, programmatic requirements, and potentially Medicare Conditions of Participation. Where potentially useful, they should seek Congressional support to engage all participants

<sup>1</sup> <https://ecqi.healthit.gov/tool/cypress>



September 13, 2021

	and evolve towards a common standards-based national information management ecosystem.
--	--

**Potential Future Alignment of Measures Across Reporting Programs, Federal and State Agencies, and the Private Sector**

What are initial priority areas for the dQM portfolio given evolving interoperability requirements (for example, measurement areas, measure requirements, tools)?	Rather than a dQM portfolio, HHS as a whole should determine a small number of broad strategic priorities that hospital-developed measures should align with. As the definition of “quality” can be variable, these broad strategic priorities will help guide eligible hospitals and CAHs, while letting them have maximum flexibility in determining how to best improve the use of their health IT to improve quality, as they define it.
---	--

**Closing the Health Equity Gap in CMS Clinician Quality Programs — Request for Information (RFI)**

*Future Potential Stratification of Quality Measure Results by Race and Ethnicity*

CMS is interested in learning more about, and soliciting comments about, the potential benefits and challenges associated with measuring hospital equity using an imputation algorithm to enhance existing administrative data quality for race and ethnicity until self-reported information is sufficiently available.

**AMIA Comments:** AMIA notes that certified EHRs are required to be able to collect and share race and ethnicity information as part of USCDI. While not included the current version of USCDI, EHR vendors can choose to update their systems to collect and share these additional data elements.

As to use of imputation algorithms to enhance existing administrative data quality for race and ethnicity, we urge CMS to first define what specific clinical outcomes it is hoping to address with the use of this enhanced data. We believe that CMS can best address health equity gaps by defining outcomes, then working backwards to understand why certain disparities exist. Only then should it be asking how an algorithm might aid in achieving improved outcomes.

*Improving Demographic Data Collection*

CMS is interested in learning about, and is soliciting comments on, current data collection practices by hospitals to capture demographic data elements (such as race, ethnicity, sex, sexual orientation and gender identity (SOGI), language preference, tribal membership, and disability status).

September 13, 2021

**AMIA Comments:** We note that in many hospitals, demographic data is collected via non-medical professional clerks, often in a public area. This method is inherently flawed in delivering high-quality data, as patients may self-censor, especially when it comes to sexual orientation and gender identity. CMS must further recognize the problematic nature of attempting to capture much of the demographic data mentioned above, given that race is a social construct and individuals may more frequently identify as mixed race over time. For some of these demographics, CMS should acknowledge and anticipate the rapidly evolving nature of their definitions.

CMS rightly recognizes that self-reported data is the gold standard and should thus incentivize the development of systems to give patients both the privacy and comfort to input the data that they want. CMS could further partner with the Census Bureau enable individuals to self-report these demographics to a centralized system, providing them an opportunity on demand to update their demographics if needed before the next Census date (e.g. updating gender identity from male to transgender male-female). This could become the national gold standard for demographic data and CMS, as well as other agencies and health care delivery organizations could access demographic data this way. This would provide a single source of true demographic data, enable self-reporting, offload health care delivery organizations from needing to ask these questions, and assure data consistency and integrity given a single national standard and repository for demographics.

### **MIPS Value Pathways**

CMS is proposing to begin transitioning to MVPs in the 2023 MIPS performance year. They are requesting public comment on the aim to sunset traditional MIPS after the end of the 2027 performance and data submission periods.

**AMIA Comments:** AMIA has long supported goal the MIPS Value Pathways (MVP) framework to simplify MIPS, improve value, reduce burden, help patients compare clinician performance and better inform patient choice in selecting clinicians. Further we support the MVP framework to support a more cohesive participation experience by connecting activities and measures from the 4 MIPS performance categories that are relevant to the population they are caring for, a specialty or medical condition. We are pleased by this express direction established by CMS to look for ways to better align payment and quality program elements to focus on outcomes. We thus support a full transition to MVPs and believe that sunseting traditional MIPS after the 2027 reporting year will provide more than sufficient lead time to develop appropriate MVPs.

However, we are disappointed in what we see as a missed opportunity to more fully transform MIPS as envisioned. CMS is proposing to bundle existing MIPS performance category options into pre-determined options and require all participants to report on the Promoting Interoperability performance category as a Foundational Layer. While this approach may result in more comparable data among members of a specific specialty (a worthy CMS goal), it will likely not result in either the sought, or optimal objectives of a MIPS transformation.

September 13, 2021

We strongly urge CMS to reconsider its decision to leave the Promoting Interoperability performance category unmodified in the MVPs. The Promoting Interoperability performance category, originally part of the EHR Incentive Program, played an indispensable role in both encouraging adoption and promoting specific functionalities of EHR use in the ambulatory setting. Indeed, we supported this measures and objectives approach at the program's inception to help new users of EHRs acclimate to specific functions, supported by specific health IT standards. As experience with EHRs has grown and functions/standards evolved, we no longer see need for a numerator/denominator measurement paradigm for health IT use.

In the initial of set of MVPs proposed for the 2023 performance year, certified health IT would be needed to calculate many of quality measures and execute the improvement activities. there is no reason to measure the use of health IT as CMS has done historically. Under this new framework AMIA strongly recommends CMS view the use of health IT as an enabler, not an end unto itself.

As CMS spends the next several years transitioning from traditional MIPS to MVPs, AMIA strongly suggests that it do so by:

- Dissolving the current numerator/denominator, measurement/objective structure of the Promoting Interoperability performance category entirely;
- Requiring, that all MVP participants have certified health IT and demonstrate use of such through reporting dQMs (already a MIPS guiding principle) and specified Improvement Activities. Participants should be given wide latitude in deciding which dQMs they should report.

We are pleased that CMS is proposing to allow clinician choice in selecting which quality measures and improvement activities to report in the MVPs. We believe that this will help to ensure that the dQMs are not only clinically appropriate, but that they are already implementable in the clinical setting, so that the measure can be collected, reported, and submitted automatically.

Improving interoperability can still be a core objective of CMS payment policy, but rather than measuring process indicators, the MVP framework provides CMS an opportunity to measure the outcome of interoperability through dQMs and certified health IT-enabled IAs. Additionally, this approach will relieve overburdened clinicians from regulatory reporting requirements and enable them to develop more efficient workflows absent considerations of how to capture numerator/denominator measures. The true opportunity to transform MIPS is to focus MVPs on a combination of quality measures and Improvement Activities that would not be possible without the use of certified health IT.

### **MIPS Performance Threshold Category Measures and Activities**

*Proposed Changes to the Query of Prescription Drug Monitoring Program Measure under the Electronic Prescribing Objective*

CMS is proposing to maintain the Electronic Prescribing Objective's Query of PDMP measure as optional and worth 10 bonus points for the CY 2022 performance period/2024 MIPS payment year.

September 13, 2021

**AMIA Comments:** AMIA supports the proposal to make the Query the PDMP measure optional for another year and maintain the 10 point bonus. In previous years, we did not believe such a measure should be required until certified health IT (CEHRT) supported it. We recommended that 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 nonetheless note, as does the NPRM, the recent progress in the availability of both standardized APIs and updated standards for e-prescribing within CEHRT. See our additional comments on the future direction for the measure below:

<p>To what degree would all MIPS eligible clinicians be prepared to report on the current attestation-based Query of PDMP measure in the near future? What additional considerations would need to be addressed before transitioning to a performance-based version of the measure?</p>	<p>There are three variables that factor into an eligible hospital’s readiness to report on the Query the PDMP measure: the state of the EHR, the specific state PDMP’s readiness, and the level of integration with the e-prescribing infrastructure and platform. We note that hospitals who are using up-to-date CEHRT should be able to meet this measure easily and routinely. While we could support making this measure required in the near future, we do not support transitioning the measure to a performance-based one and urge CMS to keep the measure attestation-based.</p>
<p>Would changes to the Query of PDMP measure be necessary to accommodate other technical approaches that may be implemented in the future, such as exchange of information with a PDMP or with multiple PDMPs using HL7® FHIR®?</p>	<p>We recommend adding an attestation statement to the measure as to whether other systems were used to obtain prescription data.</p>
<p>What, if any, exclusions should be made available as part of the measure’s specifications with regard to MIPS eligible clinicians?</p>	<p>We do not believe there should be exclusions for this measure.</p>
<p>When will State PDMPs be ready to effectively exchange data with provider systems using HL7® FHIR® to support this measure? What are the most common standards and approaches used to access PDMP data through provider systems currently?</p>	<p>We note that APIs have been activated in some PDMPs, but we do believe they are widely used yet.</p>
<p>What technical considerations exist for intrastate vs. interstate PDMP queries? How could health information exchange networks play a role in expanding access to PDMP data? In what ways could FHIR® applications be supported to safely share PDMP data within a clinician’s workflow?</p>	<p>Health information exchanges (HIE) have strong potential in expanding access to PDMP data. However, while many, if not most state PDMPs can access data from other states, the ability of HIEs to provide controlled substance prescription and fill data (depending on state) remains to be seen. These interfaces are not</p>

September 13, 2021

	<p>FHIR-based at present, and an effort to convert well-functioning PDMP query-response interfaces to FHIR does not appear to us to be a top priority.</p>
--	--

*Proposed Changes to the Provide Patients Electronic Access to Their Health Information Measure Under the Provider to Patient Exchange Objective*

CMS is proposing to, beginning in CY 2022, modify the Provide Patients Electronic Access to Their Health Information measure to require MIPS eligible clinicians to ensure that patient health information remains available to the patient (or patient-authorized representative) to access indefinitely and using any application of their choice that is configured to meet the technical specifications of the API in MIPS eligible clinician’s CEHRT. The proposed requirement would include all patient health information from encounters on or after January 1, 2016.

**AMIA Comments:** AMIA supports this proposal, including the proposed January 1, 2016 look-back date. We appreciate CMS’s efforts to align the date with the date of service start date finalized in the Patient Access and Interoperability final rule.

*Modifications to the Public Health and Clinical Data Exchange Objective*

CMS is proposing to require two of the measures associated with the Public Health and Clinical Data Exchange Objective, beginning with the performance period in CY 2022: Immunization Registry Reporting; and Electronic Case Reporting.

**AMIA Comments:** AMIA strongly supports this proposal. Even prior to the COVID-19 pandemic, we urged CMS to make public health reporting a higher priority. Specifically, we recommended 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.” We are thus thrilled that CMS has proposed to elevate these important public health measures. The data collected will be invaluable to tracking disease resurgence, monitoring outbreaks, and determining efficacy of vaccines and their boosters, for both COVID-19 and other public health threats.

Nonetheless, we still strongly urge encourage CMS to double the Promoting Interoperability Program points from 10 to 20 for public health reporting and require reporting of the Syndromic Surveillance Reporting and Reportable Lab Results Reporting (which has not appeared in the QPP for several years), as well. CMS could also allow eligible clinicians to choose Electronic Case Reporting, Public Health Registry Reporting; or Clinical Data Registry Reporting for an additional 5 bonus points. Although this is a recommendation we have made for several years, it especially salient during a public health emergency. Reporting to such registries may require significant investments on the provider’s part, but had CMS not required minimal public health reporting as part of the last eight years of the EHR Incentive Payment program, we may have had a larger communications gap between the ambulatory setting and public health today. Further, requiring MIPS eligible clinicians

September 13, 2021

to report all of these public health measures will bring these requirements into alignment with similar policies recently finalized in the CMS IPPS final rule.<sup>2</sup>

CMS must further use all policy levers at its disposal to elevate the public health objective even more. CMS should work with ONC to identify and require adherence to existing standards. Where such standards exist, adherence to them should be required to meet the Promoting Interoperability measures. For example, electronic case reporting could be achieved through participation in eCR Now, or by adhering to the HL7 CDA R2 eICR or FHIR eCR implementation guides, as referenced in ONC optional certification.

Finally, CMS should specify that reporting must also be as complete as possible. In order for them to be able to attest “yes” to actively sending data to a public health agency for the four use cases, providers and hospitals must also attest that the connections send all of the necessary information as part of the established feeds. For example, electronic case and electronic lab reports must include phone numbers, patient address, and race/ethnicity data at a greater than 95 percent completeness. Completeness of race and ethnicity data is critical to support health equity during the COVID-19 response and all reportable conditions. Additionally, complete information on reporter, provider, performing facility, and specimen type is integral to timely public health investigation and follow up. The USCDI can serve as a guidepost for the data that must be included. Attestations to the measures must confirm that they are sending complete data according to the percent selected, which can be verified with audits.

### *SAFER Guides*

CMS is proposing to add a new SAFER Guides measure to the Protect Patient Health Information objective beginning with the CY 2022 performance period/2024 MIPS payment year. A MIPS eligible clinician would have to attest to having conducted an annual self-assessment using the High Priority Practices Guide, at any point during the calendar year in which the performance period occurs, with one “yes/no” attestation statement accounting for a complete self-assessment using the guide.

**AMIA Comments:** AMIA supports CMS efforts to understand and address patient safety issues that may arise due to use of health IT, and thus supports the inclusion of this measure for CY 2022. We previously supported efforts to promote use of the SAFER Guides and policies to incentivize providers to use them and are thus please with this proposal. We further note that 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 envision would replace functional measures prescribed by CMS with clinically-relevant Improvement Activities, according to both local/regional

---

<sup>2</sup> <https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>

September 13, 2021

priority and HHS strategy. We are thus pleased that CMS is proposing making this measure attestation-based.

AMIA further 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 Improvement Activities to EHR safety activities, in that healthcare organizations should receive PI Program credit for leveraging their unique EHR safety activities and/or procedures. CMS should leverage CMMI to initiate pilots to better understand what systems and controls are needed to support an Improvement Activity program. However, we see the area of EHR safety as a good opportunity to test this concept, as well.

Based on our comments above, we recommend a slight revision to the Promoting Interoperability points allocation until the full implementation of MVPs:

*CMS Proposed, AMIA Recommended PI Program Measures & Points Allocation for 2022*

Objectives	Measures	Maximum Points	Maximum Points (AMIA recommendations)
e-Prescribing	e-Prescribing	10 points	5 points
	<i>Bonus:</i> Query of Prescription Drug Monitoring Program (PDMP)	10 points (Bonus)	10 points (bonus)
Health Information Exchange OR	Support Electronic Referral Loops by Sending Health Information	20 points	20 points
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	20 points	Request/Accept Summary of Care: 10 points
			Clinical Information Reconciliation: 10 points
Health Information Exchange (alternative)	HIE Bi-Directional Exchange	40 points	40 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points	40 points

September 13, 2021

Public Health and Clinical Data Exchange	<u>Required:</u> Immunization Registry Reporting, Electronic Case Reporting  <u>Optional:</u> Public Health Registry Reporting, Clinical Data Registry Reporting, Syndromic Surveillance Reporting	10 points	Syndromic Surveillance Reporting, Immunization Registry, Reportable Lab Results, and Electronic Case Reporting (Required): 20 points  <u>Optional:</u> Public Health Registry Reporting; Clinical Data Registry Reporting: 5 points (bonus)
--	--	-----------	---

*Request for Information regarding the COVID-19 Vaccination by Clinicians Measure*

CMS is proposing the inclusion of a COVID-19 vaccination by clinicians measure within the quality measure set for MIPS. The measure would assess the percentage of patients over 18 who have completed the COVID-19 vaccination series during the measurement period. The measure would be reported by MIPS eligible clinicians to determine the percentage of patients seen for a visit during the measurement period who have ever completed or reported having ever completed a COVID-19 vaccination series, either from the submitting MIPS eligible clinician or another MIPS eligible clinician.

**AMIA Comments:** AMIA supports the inclusion of this measure as *optional* within the MIPS quality measure set. We recommend, however, that CMS update the measure specifications to allow providers to meet this measure by verifying vaccine status through their regional Immunization Information System (IIS), or immunization registry, which will also ensure they are sending and receiving immunization data. Further, because many patients received their COVID-19 vaccinations outside of their physicians’ offices—including pharmacies and mass vaccination sites—bidirectional connections between EHRs and immunization registries will ensure that physicians are reporting complete and accurate data for all patients. While we do not believe that this measure should become required of a MIPS eligible clinician, it provides another avenue for them leverage their certified health IT to further public health goals.