



September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: [CMS-1770-P] - CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Comments submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure:

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

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

In general, AMIA supports a deliberate yet incremental approach to the expansion of data collection initiatives. A balance must be achieved between the addition of data fields and a recognition of the need to minimize burden on front line providers. Further, there is a need to

tie data collection to clinical relevance. Recent CMS rules related to “patients over paperwork” and “provider burden reduction” offer opportunities for clinicians to document clinically meaningful data rather than data only needed for administrative or billing purposes. Such purposeful clinical documentation best informs the care process, supports clinical decision support, and more accurately reflects care quality. The value of data collection is well established for quality and safety. High quality clinical data will better inform health policy as we strive to achieve health equity and reduce health disparities.

AMIA believes CMS proposals to advance data collection should be viewed in the context of other data collection initiatives across federal government programs to ensure that additional data collection will both be clinically meaningful and inform broader health policy initiatives including advancing health equity. Further, we caution that due to the uniquely sensitive nature of social determinants of health (SDOH) data, emphasis should be placed on standards-based data, data collection and reporting, while maintaining paramount respect for patient autonomy and privacy.

AMIA supports better integration, interoperability, and bi-directional sharing of data, information, and knowledge across care delivery, public health agencies, and community-based organizations. Such data are necessary to drive prevention and disease management efforts, to support community resource information sharing and to inform public policy. We emphasize that while bi-directional sharing of data is critical there now exists variation in policy and capability across state and local health entities. As we experience these challenges we encourage engagement from CMS and other federal government agencies (e.g. Centers for Disease Control) to advocate for national standards.

Transition to Digital Quality Measurement

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

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

Advancing TEFCA

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

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

AMIA urges CMS to be mindful that requiring exchange under TEFCA could pose a burden to hospitals and health systems under resource constraints. We encourage exemptions or extended compliance timelines for such facilities.

Promoting Interoperability Performance Category

CMS proposes to add a new Enabling Exchange Under TEFCA measure in the Promoting Interoperability performance category. This proposed measure would provide eligible clinicians with the opportunity to earn credit for the Health Information Exchange objective if they: are a signatory to a "Framework Agreement" as that term is defined in the Common Agreement; enable secure, bi-directional exchange of information to occur for all unique patients of eligible clinicians, and all unique patient records stored or maintained in the EHR; and use the functions of CEHRT to support bidirectional exchange.

AMIA supports adding this as an option.

Thank you for your consideration of these comments. If you require additional information, please contact Reva Singh, JD, AMIA Vice President of Public Policy, at rsingh@amia.org.

Sincerely,

A handwritten signature in blue ink that reads "Gretchen P Jackson". The signature is written in a cursive, flowing style.

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