



December 14, 2015

The Honorable Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3310 & 3311-FC  
Submitted electronically at: <http://www.regulations.gov>

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017

Dear Administrator Slavitt:

The American Medical Informatics Association (AMIA) appreciates the opportunity to submit comments regarding the Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 through 2017. This final rule was published with an open comment period by the Centers for Medicare & Medicaid Services (CMS) in the October 16, 2015, issue of the *Federal Register*.

AMIA is the professional home for more than 5,000 informatics professionals, representing researchers, front-line clinicians 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 members play 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.

We appreciate your recognition of the need to provide a comment period to this final rule, and we understand CMS is urging comment on how best to ensure alignment between meaningful use (MU) and policies resulting from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Given this understanding, we will not comment on specific measures and objectives finalized by this rule. Rather, we offer a set of guiding principles CMS policymakers should apply to the program redesign of MU, beginning immediately. **CMS must evolve the MU program to be a pathway through which physicians can iterate towards Alternative Payment Models (APMs), using robust and responsive health informatics tools, and in a way that aligns with HHS goals for shifting Medicare reimbursement from volume to value.**<sup>1</sup> Our intention is to make MU a valuable policy driver through which all stakeholders can better contribute to and benefit from the learning health and healthcare system (LHHS).

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<sup>1</sup> Department of Health and Human Services, "In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," Jan. 26, 2015 <http://1.usa.gov/1kMBssl>

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Consistent with recommendations offered by the AMIA EHR 2020 Task Force,<sup>2</sup> and in order to meet the needs of the Merit-based Incentive Program System (MIPS) and Alternative Payment Models (APMs), CMS should evolve MU employing four guiding principles:

1. CMS should seek to further simplify MU requirements and ease reporting burdens for participating eligible professionals (EPs);
2. CMS should continue its focus on improving care quality by encouraging data exchange and interoperability;
3. CMS should view MU as a means to gain insights into the care delivery system, apart from what quality measures depict; and
4. CMS should ensure a robust clinical informatics workforce supports the ongoing evolution of data-driven health and healthcare.

Implicit across these principles is the notion that we are moving away from a fee-for-service payment paradigm, and CMS should use this opportunity to revisit policies meant to spur adoption and guide use of health IT. These principles are not mutually exclusive, and we encourage CMS to reimagine MU in a way that acknowledges the permanency of EHRs and other informatics tools in everyday practice, for the care of every American.

In comments submitted to CMS as part of this rule's notice of proposed rulemaking (NPRM) AMIA recommended CMS wait to issue a final rule until after performance experience from 2015 could be assessed.<sup>3</sup> We supported many of the proposed modifications to MU, agreeing with CMS's view that the changes would result in a more streamlined, harmonized approach to compliance.

**However, the adjustments made to Stage 2 of the program should not have served as a foundation for the continuation of a highly-prescriptive, complex and expensive regulatory schema for Stage 3.**

In much the same way that fee-for-service era policies skewed incentives and provider behavior, overly prescriptive documentation and functional "use" requirements of the same era have influenced how health IT is developed, implemented and leveraged to improve care. For the majority of successful EPs, Stage 3 should represent an opportunity to utilize informatics tools in novel ways, suited to specific care settings and patient population needs.

AMIA recommends CMS consider the following changes to MU so that it encourages innovative and effective use of informatics tools:

1. Elimination of MU measure threshold requirements, so that success is redefined by participation, and results of participation are leveraged to learn rather than grade;

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<sup>2</sup> Payne, T., Corley S., Cullen T., et al. Report of the AMIA EHR-2020 Task Force on the status and future direction of EHRs. *J Am Med Inform Assoc* 2015; 22(5): 1102–1110

<sup>3</sup> AMIA Comments to CMS Regarding the Electronic Health Record Incentive Program-Stage 3 Proposed Rule, May 2015 <https://www.amia.org/sites/default/files/AMIA-CMS-Stage3-NPRM-Response-2015-05-29.pdf>

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2. Establish multiple tracks to meet MU depending on MIPS or APM participation, and depending on whether or not participants wish to engage in one of several programs / use cases that portend robust use of informatics tools.
  - a. Redefine all measures finalized for the EHR Incentive Programs for 2015 through 2017 (80 FR 62762 through 62955) as part of a menu set from which providers could choose a minimum number of practice-relevant measures to gain full credit for MU under MIPS;
  - b. Allow EPs and EAs to get credit for MU by participating in HHS-designated programs, such as the Million Hearts campaign, that would require robust use of health informatics tools; and
  - c. Enable organizations to apply for waivers, sponsored by their medical specialty, with plans outlining alternative uses of health IT that are comparable to measures finalized as part of 80 FR 62762 through 62955.
3. Enable the statutory requirement to submit quality measure data to be fulfilled by participating in electronic submission data as part of PQRS or through submission to Qualified Clinical Data Registries (QCDRs).

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](mailto:jsmith@amia.org) or (301) 657-1291. We look forward to continued partnership and dialogue.

Sincerely,



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



Blackford Middleton, MD, MPH, MSc  
Harvard TH Chan School of Public Health  
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AMIA Board of Directors