September 27, 2019

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Submitted electronically http://www.regulations.gov

Re: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies Notice of Proposed Rulemaking

Dear Administrator Verma:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the CY2020 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 strongly supports CMS efforts to address documentation burden through evaluation and management (E/M) guideline reform and we are supportive of the MIPS Value Pathways framework described in this proposed rule. Below we offer additional insights and observations from our clinical informatics community.

**Evaluation and management guideline requirements**

AMIA supports CMS proposals to amend documentation requirements related to evaluation and management (E/M) guidelines. From an informatics perspective, the removal of history and physical exam requirements and the option to document using time or medical decision-making (MDM) represents the greatest opportunity medicine has had to re-think how the patient’s story is captured.
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and conveyed for care continuity. The use of more interoperable information technology systems, sensors, audio and visual data streams, and other advances could all but remove documentation burden for billing and audit purposes, leaving the clinician and her patient to focus on the aspects of care delivery that matter most.

However, we anticipate that simply removing these documentation burdens will be insufficient. First, reimbursement incentives and fears of audit will continue to perpetuate the practice of over-documentation. Fee-for-service care delivery continues to incentivize volume over value, and while the MIPS program has emphasized quality and resource use measurement, we anticipate the inertia around FFS may be among the largest impediments to realizing the relief this policy change may make. AMIA supports CMS efforts to incentivize participation in alternative payment models (APMs) and we recommend CMS work with specialty societies to establish benchmarks for both clinicians and auditors around best practices for MDM and time-based billing.

Second, data capture and documentation solutions are immature and more closely resemble adaptation of paper-based forms than true alternatives. EHR functionality continues to reflect a paper-based environment, which in today’s electronic environment fails to generate interoperable data making finding, accessing, extracting, and reusing challenging. AMIA recommends CMS support development of solutions, such as multi-professional, interdisciplinary-based notes, sensors and remote monitoring, voice dictation and video capture, natural language processing solutions, automated diagnosis generation, diagnosis based clinical decision support, machine learning and artificial intelligence etc. CMS must also support Health IT Certification and continued data standardization.

Third, compliance with CMS quality and payment programs will continue to hamper EHR usability and compel atypical workflows. Regulatory reporting requirements associated with the Promoting Interoperability Program and misalignment of quality measures for public and private payers will continue to complicate documentation. AMIA supports CMS burden reduction efforts and we were pleased to learn of plans to establish an Office of Burden Reduction.1 A key focus area for this office should be to explore the use of monitoring tools to display quality measure output and seamlessly report quality outcome measures. As an example, there are more than 1 million hospitalizations for Heart Failure (HF) annually. It is widely known that patients hospitalized for HF are at high risk for all-cause rehospitalization, with a 1-month readmission rate of 25%.2 Among patients with HF in one large population study, hospitalizations were common after HF diagnosis,

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with 83% of patients hospitalized at least once and 43% hospitalized at least 4 times.\textsuperscript{3,4,5} EHR technology and interoperability data may be readily extracted from EHRs providing clinical decision support, assuming appropriate testing is performed in a timely manner, medication dose, route and frequency is accurately selected for designated patient populations, and continuing assessment forms are completed.

Fourth, and perhaps most difficult, a whole generation of clinicians know of no other way to tell the patients story, but through E/M guideline requirements, drop down menus, and cut/paste functionality. There will need to be a concerted effort to train clinicians how to write a meaningful narrative. AMIA reiterates our recommendation that CMS work with specialty societies to develop model notes for MDM and time-based billing.

**MIPS Value Pathways Framework**

AMIA supports the goal of CMS’s concept of new 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. For the last three years, AMIA has recommended CMS look for ways to better align payment and quality program elements to focus on outcomes and we are encouraged by this express direction established by CMS.\textsuperscript{6,7,8}

However, we are concerned that CMS is missing an important opportunity to more fully transform MIPS as envisioned. As we understand it, 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 similar to current requirements. While this approach may result in more comparable data among members of a specific specialty, it will not likely result in the sought objectives of a MIPS transformation.

\textsuperscript{7} https://www.amia.org/public-policy/amia-urges-cms-focus-health-it-improvement-activities-hospital-payment-rule
\textsuperscript{8} https://www.amia.org/public-policy/amia-comments-cms-innovation-center-rfi
September 27, 2019

To do more than repackage MIPS, we urge CMS to reconsider its decision to leave the Promoting Interoperability performance category unmodified as it becomes incorporated into the MVP framework. The Promoting Interoperability performance category as an antecedent to the EHR Incentive Program has played an important role in both encouraging adoption and promoting specific functionalities of EHR use in the ambulatory setting. In the early stages of this program, we supported such an approach, underpinned by measures and objectives, to help coalesce new users of EHRs around specific functions, supported by specific health IT standards. As experience with EHRs grows and functions/standards evolve, we no longer see need for a numerator/denominator measurement paradigm for health IT use.

In the MVP examples provided by CMS in this NPRM, 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 considers a new MVP framework, AMIA strongly suggests that it do so by:

• Empowering specialty societies to be key stakeholders in the development of MVPS;
• Establish MVPS as an option, initially, to garner input and feedback from participating clinicians;
• Dissolving the current numerator/denominator, measurement/objective structure of the Promoting Interoperability performance category;
• Require that all participants of the MVP framework possess certified health IT and demonstrate use of such through specified Improvement Activities (IAs) and reporting of electronic clinical quality measures (eCQMs).

Improving interoperability can still be a core objective of CMS payment policy, but rather than measuring process indicators, the concept of MVPS provides CMS an opportunity to measure the outcome of interoperability through eCQMs 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.

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.
September 27, 2019

Sincerely,

Douglas B. Frdisma, 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 PFS NPRM)
Proposed Policies for CY 2021 for Office/Outpatient E/M Visits

Office/Outpatient E/M Visit Coding and Documentation
CMS is proposing to adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA/CPT. Under this new framework, history and exam would no longer select the level of code selection for office/outpatient E/M visits. Instead, an office/outpatient E/M visit would include a medically appropriate history and exam, when performed. For levels 2 through 5 office/outpatient E/M visits, the code level reported would be decided based on either the level of MDM (as redefined in the new AMA/CPT guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time).

AMIA Comments: AMIA supports adoption of the new framework described by CMS to remove the role that history and exam plays in determining level of code selection for office/outpatient E/M visits. We also support removal of the number of body systems/areas reviewed requirements for E/M visits, except and to the extent they are clinically appropriate.

AMIA Comments: AMIA supports MDM or time-based documentation for levels 2 through 5 E/M visits and the removal of minimum supporting documentation associated with level 2 office/outpatient E/M visits. These changes will significantly reduce documentation burden and enable clinicians to redirect their efforts to direct patient care. These proposals will also provide an opportunity to leverage new technologies to accurately convey MDM and total time personally spent by the reporting practitioner.

However, we note that in many instances reporting practitioners will review patient records before or after the day of the visit. Reimbursement schemas based on total time should acknowledge these workflow dynamics and include time spent preceding (or subsequent to) the day-of visit.

MIPS Program Details: Transforming MIPS: MIPS Value Pathways Request for Information

MVP Guiding Principles
CMS requests public comments on the MVP guiding principles regarding reducing burden, providing comparative performance data to patients and caregivers, encouraging improvements in high priority areas, and reducing barriers to APM participation.

AMIA Comments: AMIA supports these guiding principles. We recommend supplementing Principle 3 by stating explicitly “high priority areas of morbidity and mortality.” We urge CMS to establish a consensus process similar to the National Quality Strategy9 to identify these priority areas.

9 https://www.ahrq.gov/workingforquality/index.html
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Additionally, AMIA recommends a fifth Principle to ensure that “MVPs should be aligned with CMS policies and programs for inpatient and post-acute care settings.” We remind CMS that MIPS eligible clinicians represent but a fraction of all regulated clinicians and organizations. It is important that CMS remains cognizant of how MVPs may impact other payment and quality performance programs and seek to align wherever possible.

MVPs and Promoting Interoperability Performance Category
CMS is not considering making modifications to the Promoting Interoperability performance category as it becomes incorporated into the MVP framework. CMS is seeking comment on how the Promoting Interoperability performance category could evolve in the future to meet its goal of greater cohesion between the MIPS performance categories.

AMIA Comments: We agree that the meaningful use of certified EHR technology to support care coordination and electronic health information exchange should be a key structural part of any MVP. We also agree that interoperability is a foundational element that applies to all clinicians, regardless of MVP.

Given these shared views on the importance of certified EHR technology and interoperability, we strongly urge CMS to consider that measuring the meaningful use of EHRs is counterproductive at this point of adoption. We urge CMS to consider that a wide range of quality measurement and quality improvement activities simply are not feasible without the use of certified health IT.

For example, the American College of Physicians has identified potential health IT activities10, including:

- EHR/Health IT educational activity developed/endorsed by medical specialty or professional societies;
- Precision Medicine/Learning Health System (e.g., participation in practice-based research or other observational study efforts);
- Clinical Informatics Improvement (e.g., support of iterative improvement in practical informatics via use of an “EHR feedback” application; or participation in an EHR user group);
- Quality, Safety, Value Improvement Projects that Leverage Health IT;
- Patient Safety and Near-miss Reporting; and
- Development of eCQMs that support Quality Improvement (done within a QCDR).

As such, AMIA strongly recommends that CMS consider MVPs that leverage certified health IT and include only the core statutory requirements for successful Promoting Interoperability Program participation: electronic prescribing; quality measurement; and information exchange. In the examples provided by CMS in this NPRM, certified health IT would need to be used to calculate the quality measures and execute the improvement activities – there is no reason to measure the use of health IT as CMS has done historically.

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10 https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf
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It is time that CMS discontinue the practice of implementing policy through the required use of technology. In the earliest days of EHR adoption such training wheels were necessary to help a paper-based industry begin to digitize. This is no longer the case.

**MVPs and Improvement Activities**
CMS is seeking feedback on how many improvement activities should be included in an MVP and how much flexibility there should be in selecting improvement activities. CMS also seeks feedback on the extent to which improvement activities in MVPs should be specialty-specific, condition-focused improvement activities, versus other areas relevant to the practice such as patient experience and engagement, team-based care, and care coordination. CMS is also interested in feedback on whether improvement activities should focus on improving the quality and cost measures within an MVP or be much broader including any improvement activities that are relevant to the practice.

**AMIA Comments:** AMIA has been a strong supporter of Improvement Activities (IAs) to encourage innovation in ways that are relevant to unique eligible clinicians. Numerous of these IAs merely require yes/no attestation or proof of participation in a qualifying program. Very few IAs require verifiable data or result in a score that is easily translated into an MVP rubric.

In alignment with our comments regarding the Promoting Interoperability portion of MVPs, AMIA recommends CMS identify and encourage MVP participants to choose IAs that would rely on the use of certified health IT to be accomplished. To the question of flexibility CMS poses, our recommendation would support specialty-specific, condition-focused IAs, as well as patient experience and engagement, team-based care, and care coordination. Limiting the IAs to those that rely on certified health IT obviates the need to limit in these other ways. Again, CMS should identify and limit IAs by whether they rely on certified health IT to accomplish.

**MVP Selection**
CMS is interested in feedback on the level of choice that should be provided to clinicians for MVP selection or selection of measures and activities within an MVP. CMS is requesting public comments on whether clinicians and groups should be able to self-select an MVP or if an MVP should be assigned.

**AMIA Comments:** CMS should initially begin with a menu approach where clinicians and groups can self-select MVP(s). We anticipate that specialty societies could be important contributors to the options that CMS provides and we recommend CMS initiate an effort to empower specialty societies to draft MVPs relevant to their members’ focus areas.

**Enhancing Information for Patients**
CMS believes implementing an MVP framework will transform the MIPS program by better informing and empowering patients to make decisions about their healthcare and helping clinicians achieve better outcomes, and also by promoting robust and accessible healthcare data and interoperability.
AMIA Comments: AMIA supports the incorporation of patient feedback into clinician’s performance evaluation and we agree that better information will empower patients to make decisions about their healthcare. However, we caution CMS against placing too much responsibility to decipher data and parse complex levels of information. Empowering patients should not come at a cost of burdening them. We recommend that CMS studies what information patients want and design user-friendly approaches to sharing this data with patients.

MIPS Performance Category Measures and Activities

Contribution to Final Score
CMS is seeking comment on its proposals to incrementally reduce the weight of the quality performance category as it gradually increases the weight of the cost performance category. Specifically, the quality performance category will comprise 40 percent of a MIPS eligible clinician’s final score for the 2022 MIPS payment year, 35 percent for the 2023 MIPS payment year, and 30 percent for the 2024 MIPS payment year and future years. Meanwhile, the cost performance category will increase from the existing weight of 15 percent for the 2021 MIPS payment year to 30 percent beginning with the 2024 MIPS payment year.

AMIA Comments: We understand that the decrease in the quality performance category’s contribution to the final score is statutory. We appreciate CMS’s transparency in how both this, and the cost performance category, will be weighted over the next several reporting years.

Quality Data Submission Criteria
CMS proposes that MIPS eligible clinicians and groups submitting quality measure data on QCDR measures, MIPS CQMs, and eCQMS must submit data on at least a 70 percent of the MIPS eligible clinician or group’s patients that meet the measure’s denominator criteria, regardless of payer for the 2020 MIPS performance period.

AMIA Comments: AMIA supports increasing the data completeness threshold.

Promoting Interoperability
Performance Category Performance Period
CMS is proposing for the 2023 MIPS payment year, establishing a performance period of a minimum of a continuous 90-day period within CY 2021, up to and including the full calendar year.

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

Performance Category Measures for MIPS Eligible Clinicians
CMS is proposing to make the Query of PDMP measure optional and eligible for 5 bonus points for the Electronic Prescribing objective in CY 2020. CMS is also proposing that, in the event it finalizes this proposal for the Query of PDMP measure, the e-Prescribing measure would be worth up to 10 points in CY 2020.
In addition, beginning with the 2019 performance period, CMS is proposing to remove the numerator and denominator that CMS established for the Query of PDMP measure in the CY 2019 PFS 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 measurement and towards an activity-based approach.

CMS is proposing to remove the Verify Opioid Treatment Agreement measure from the Promoting Interoperability performance category beginning with the performance 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.

CMS is proposing, beginning with the 2019 performance period/2021 MIPS payment year, to redistribute the points for the Support Electronic Referral Loops by Sending Health Information measure to the Provide Patients Access to Their Health Information measure if an exclusion is claimed. CMS has chosen to redistribute the points to the Provide Patients Access to Their Health Information measure because CMS believes that many MIPS eligible clinicians may be eligible to claim exclusions for both measures under the Health Information Exchange objective.

**AMIA Comments:** AMIA supports this proposal. However, we once again recommend that CMS finalize the Support Electronic Referral Loops by Receiving and Incorporating Health Information in 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.

CMS is proposing to revise the description of the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure exclusion to track the description of the Request/Accept Summary of Care measure exclusion: Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient fewer than 100 times during the performance period.

**AMIA Comments:** If this measure is to be finalized as one measure, then AMIA supports this clarification to the exclusion description.

CMS is proposing to: (1) make the Query of PDMP measure optional and eligible for five bonus points in CY 2020; (2) make the e-Prescribing measure worth up to 10 points in CY 2020, in the
event CMS finalize the proposal for the Query of PDMP measure; and (3) remove the Verify Opioid Treatment Agreement measure beginning in 2020.

**AMIA Comments:** Based on our comments, we recommend a slight revision to the points allocation (see Table 1 below):

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

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Maximum Points</th>
<th>Maximum Points (AMIA recommendations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-Prescribing</td>
<td>e-Prescribing</td>
<td>10 points</td>
<td>5 points</td>
</tr>
<tr>
<td></td>
<td>Query of Prescription Drug Monitoring Program (PDMP)</td>
<td>5 points (Bonus)</td>
<td>5 points (bonus)</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic Referral Loops by Sending Health Information</td>
<td>20 points</td>
<td>20 points</td>
</tr>
<tr>
<td></td>
<td>Support Electronic Referral Loops by Receiving and Incorporating Health Information</td>
<td>20 points</td>
<td>Request/Accept Summary of Care: 10 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Information Reconciliation: 10 points</td>
</tr>
<tr>
<td>Provider to Patient Exchange</td>
<td>Provide Patients Electronic Access to Their Health Information</td>
<td>40 points</td>
<td>40 points</td>
</tr>
<tr>
<td>Public Health and Clinical Data Exchange</td>
<td>Choose two of the following: Immunization Registry Reporting</td>
<td>10 points</td>
<td>Syndromic Surveillance Reporting, Immunization Registry and Reportable Lab Results (Required)</td>
</tr>
<tr>
<td></td>
<td>Electronic Case Reporting</td>
<td></td>
<td>Choose one or more additional: Electronic Case Reporting, Public Health Registry Reporting; Clinical Data Registry Reporting</td>
</tr>
<tr>
<td></td>
<td>Public Health Registry Reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Data Registry Reporting</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Syndromic Surveillance Reporting</td>
<td>20 points</td>
<td></td>
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</table>
CMS is seeking input through Requests for Information as follows: (1) Potential Opioid Measures for Future Inclusion in the Promoting Interoperability performance category, (2) NQF and CDC Opioid Quality Measures, (3) a Metric to Improve Efficiency of Providers within EHRs, (4) the Provider to Patient Exchange Objective, (5) Integration of Patient-Generated Health Data into EHRs Using CEHRT, and (6) Engaging in Activities that Promote the Safety of the EHR. Below, AMIA reiterates its comments submitted to CMS as part of its IPPS NPRM response:

**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.

<table>
<thead>
<tr>
<th>CMS Question</th>
<th>AMIA Response</th>
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<tbody>
<tr>
<td>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.</td>
<td>As described in “Creating Patient Centered Team-based Primary Care,”[11] 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...</td>
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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, 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.
<table>
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<tr>
<th>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?</th>
<th>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 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.</th>
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<tbody>
<tr>
<td>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?</td>
<td>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.</td>
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Once again, the CMS Innovation Center could provide funding to further investigate the potential applications of RPA to healthcare providers and healthcare systems.

### 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:

<table>
<thead>
<tr>
<th>CMS Question</th>
<th>AMIA Response</th>
</tr>
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<tbody>
<tr>
<td>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?</td>
<td>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.</td>
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<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>CMS is seeking comment on posting the data on its Hospital Compare website, found at: <a href="http://www.medicare.gov/hospitalcompare">www.medicare.gov/hospitalcompare</a>.</td>
<td>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.</td>
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</table>
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.  

CMS is specifically seeking public comment on the following question: if ONC’s proposal for a FHIR-based API certification

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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.13 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:

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<th><strong>CMS Question</strong></th>
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<td>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?</td>
<td>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.</td>
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<td>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?</td>
<td>We recommend CMS consider this measure as a bonus for the objective, rather than an alternative.</td>
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<td>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?</td>
<td>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.</td>
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13 See page 11. AMIA Response to ONC 21st Century Cures Act NPRM. Available at: [https://www.amia.org/sites/default/files/AMIA-Response-to%20ONC-Cures-NPRM.pdf#page=11](https://www.amia.org/sites/default/files/AMIA-Response-to%20ONC-Cures-NPRM.pdf#page=11)
In the long term, how do stakeholders believe such an alternative measure would impact burden?

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<th>In the long term, how do stakeholders believe such an alternative measure would impact burden?</th>
<th>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.</th>
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<td>What data elements do stakeholders believe are of greatest clinical value or would be of most use to health care providers to share in a standardized electronic format if the complete record was not immediately available?</td>
<td>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.</td>
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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:

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<td>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?</td>
<td>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.</td>
</tr>
<tr>
<td>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</td>
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| What criteria should CMS employ, such as specific goals or areas of focus, to identify high priority health IT activities for the future of the program? | As part of our continued recommendations that CMS move towards accepting hospital-submitted Inpatient Improvement Activities (IIAs), we recommend that CMS 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\(^\text{14}\) 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

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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\(^{15}\) 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 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\(^8\) 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**

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 health 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:

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<td>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</td>
<td>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(^9) that a vast majority of Americans (96%) now own a cellphone of some kind. Having wellness and health apps, connected</td>
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\(^9\) [https://www.pewinternet.org/fact-sheet/mobile/](https://www.pewinternet.org/fact-sheet/mobile/)
capturing advanced directives and pre/post-operation instructions in surgery units. 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 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 it into their CEHRT. The CMS Innovation Center could prioritize innovation models that stress the capture and use of PGHD. |
| 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 IIAAs. |

**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
AMIA Response to CY2020 PFS Proposed Rule

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 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.