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June 28, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1752-P

Dear Administrator Brooks-LaSure:

The eHealth Initiative (eHI) appreciates the opportunity to comment on the Calendar Year 2022 Medicare Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System proposed rule.

eHI is a multi-stakeholder member organization dedicated to promoting innovation in health care to improve access and lower costs. We appreciate CMS' continued commitment to ensuring patient access to data and health data interoperability and believe both are necessary to ensure a high-quality health care system.

General Comments

eHI is a strong supporter of the ONC Cures Act Final Rule and the CMS Interoperability and Patient Access Final Rule, both of which intersect with many provisions in this proposed rule. Given the complexity of the requirements and numerous compliance and enforcement dates in both rules, we believe it critical that CMS and ONC work together to align regulatory timelines and requirements to the extent possible. Clinicians, hospitals, and health systems are still dealing with the impact of COVID-19 and should not face unnecessary regulatory burden due to unclear and misaligned requirements across federal agencies.

Specific Comments

Prescription Drug Monitoring Program

CMS proposes to retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure for CY 2022 and to make it worth 10 bonus points, up from 5 points in CY 2021. We support this proposal for the reasons stated by CMS. Despite slower than desired progress, integration of

PDMPs with EHRs, including the ability to query PDMPs, is very valuable and we believe that CMS strikes the right balance. Moving forward, eHI supports CMS' considering use of HL7 FHIR to facilitate PDMP/EHR data exchange.

Health Information Exchange (HIE) Bi-Directional Exchange

In the proposed rule, CMS proposes a new optional measure, "Health Information Exchange (HIE) Bi-Directional Exchange," which hospitals could attest to instead of two existing measures: "Support Electronic Referral Loops by Sending Health Information" measure and "Support Electronic Referral Loops by Receiving and Incorporating Health Information."

We support this proposed optional measure, the proposed value, and reporting by attestation rather than needing to track numerators and denominators. As outlined below, we do, have suggestions for refining the proposed attestations to better reflect the current and anticipated state of bi-directional interoperability.

CMS proposes that hospitals would attest to:

- *Participating in an HIE in order to enable secure, bi-directional exchange of information to occur for all unique patients admitted to or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23), and all unique patient records stored or maintained in the EHR for these departments, during the EHR reporting period in accordance with applicable law and policy.*

CMS uses "HIE" as a noun but does not define the term. Elsewhere in the preamble in discussing on this proposed measure, CMS uses HIE as a verb as well. We are concerned that a focus on HIEs as a noun, but with the term undefined, could exclude models that might not be formally identified as HIEs but that would meet the measure's intent, especially for national-level exchange. In addition, participation in just one HIE might not meet the need of the measure to support HIE for "every patient encounter, transition or referral." ***We suggest that the measure should be expanded to "HIEs, exchange frameworks, or other organizations focused on bi-directional health information exchange." We also suggest that CMS consider cross-referencing the definition of HIEs and HINs established by the Office of the National Coordinator for Health IT in 45 CFR § 171.102.***

- *Participating in an HIE that is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and not engaging in exclusionary behavior when determining exchange partners.*

CMS states that ". . . we would exclude exchange networks that only support information exchange between affiliated entities, such as health care clinicians that are part of a single health system, or networks that only facilitate sharing between health care practices that use the same EHR vendor." ***We ask CMS to clarify that, if such a practice or vendor-specific network connects with a regional or national exchange framework that***

enables connection across “a broad network of unaffiliated exchange partners,” this connection would enable the attestation. Within this new measure, an operational HIE connection should be counted as meeting the measure if it is a single vendor network with an operational connection to an inter-network bridge. We also believe clinicians should not be held responsible for attesting to the actions of the HIE in which they participate and ask CMS to add language to the attestation to read “...and does not, to the best of my knowledge, engage in exclusionary behavior when determining exchange partners.” Finally, we request that CMS be clear that the focus is the ability for exchange rather than actual exchange for all patients, especially as exchange may not be needed in some cases and in many models, exchange only occurs when patient data is actively queried.

- *Using the functions of CEHRT to support bi-directional exchange with an HIE.*

CMS notes that in order to report on this optional measure, “the eligible hospital or CAH must use the capabilities defined for CEHRT to engage in bi-directional exchange via the HIE, which includes capabilities which support exchanging the clinical data within the Common Clinical Data Set (CCDS) or the United States Core Data for Interoperability (USCDI).” *We agree that the applicable CEHRT functions should be used for this measure but also ask that CMS acknowledge that capabilities used may go beyond what is certified, including technologies that are not subject to certification.*

Proposed New SAFER Guides Measure

CMS is proposing that an eligible hospital or CAH must attest to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs, with one “yes/no” attestation statement accounting for a complete self-assessment using all nine guides.

eHI does not support the addition of this measure. As CMS notes, the SAFER Guides have not been updated since 2016 and are not widely used in the marketplace today. While we support measures to address health IT safety, we believe ONC should revisit and update the SAFER Guides, as appropriate, or consider other tools more widely used, accepted, and implemented in hospitals.

Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT Attestation

CMS is proposing to remove two of the three attestation statements related to prevention of information blocking. Beginning in CY 2022, eligible hospitals and CAHs will only have to attest to the following:

- *Statement 1: Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.*

eHI supports this change for the reasons outlined by CMS.

Conclusion

eHI appreciates the opportunity to comment on the Calendar Year 2021 Medicare Physician Fee Schedule and Quality Payment Program proposed rule and we look forward to continuing to work with CMS to advance and support technology-enabled health care delivery and innovation.

Sincerely,



Jennifer Covich Bordenick
Chief Executive Officer