

Administrator Selma Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

September 10th, 2018

Re: Comments on Proposed Rule-CMS-1693-P

Dear Administrator Verma,

The Promoting Interoperability for Public Health Task Force (Task Force) thanks you for the opportunity to comment on the proposed rule CMS-1693-P modifying the Medicare Quality Payment Program (QPP) and the Merit-Based Incentive Payment System and updating the Medicaid Promoting Interoperability Program.

The Task Force consists of representatives from public health organizations across the country. Meeting regularly, the Task Force has developed resources to assist public health agencies in advancing Promoting Interoperability programs' goals. We have produced guidance that agencies can use in declaring readiness and supporting providers as they engage with public health to exchange data. We engage with the Office of the National Coordinator, the Centers for Disease Control and Prevention, and CMS to advise the agencies regarding opportunities for improved collaboration.

The Task Force recognizes the work the Centers for Medicare and Medicaid Services (CMS) is advancing to enhance the delivery of health care through improving interoperability and the use of Certified Electronic Health Record Technology. We would like to bring several issues to your attention prior to finalizing the rule.

Public Health and the Future of Promoting Interoperability

In the proposed rule, CMS asked for input regarding the future of exchanging data with public health as ongoing component of CMS' *Promoting Interoperability* programs. The Task Force believes that continuing to include public health in *Promoting Interoperability* is critical to help achieve the shared aims of significant cost savings, superior patient experience, improved health, and provider satisfaction.

Public health organizations are important elements in the health care delivery network. meeting a variety of stakeholders' needs by:

- Serving individual patients by providing health care services such as immunizations, genetic counseling services, and managing the care of infectious diseases such as tuberculosis;

- Serving health care providers through the exchange of person-level information such as immunization histories, cancer treatment histories, and laboratory results, as well as access to population-level information;
- Medical researchers by sharing information collected through public health registries; and
- Serving local, state, and federal policy-makers by sharing data collected through syndromic surveillance activities, disease surveillance, and other public health activities to inform public policy decision-making.

Exchanging this kind of data builds upon CMS' goals for the exchange of health information. It leverages the same information and the same connections to provide care to individuals, improves providers' ability to coordinate health care services, promote health, and prevent disease, and supports improving population health.

Exchanging data with public health through CEHRT has significant, positive impacts on reducing provider burden while supporting the delivery of superior patient care. This exchange of data improves providers' ability to deliver care to their patients through services including:

- Giving health care providers immediate access to patients' immunization histories and related clinical decision support systems,
- Supporting information exchange with birth defects and other registries to enable better management of patients' medical conditions and support the timely delivery of necessary services,
- Interoperability with public health laboratories for order submissions and accessing results, and
- Using Electronic Case Reporting (ECR) to provide public health with patient-level, case-specific information that can assist in the rapid response necessary to manage contagious health and emerging health issues.

CMS' *Promoting Interoperability* programs have helped increase provider recognition of these types of resources and participation in these kinds of programs offered by public health. There is still work needed to extend services to include the complete range of potential providers, improve bi-directional exchange, and improve the ability to get the right information to the right decision-makers at the right time.

Including exchange with public health as an on-going requirement of *Promoting Interoperability* programs benefits all partners by:

- Recognizing the collaboration of public health and other health care service providers in improving patients' health,
- Reinforcing the importance of sharing information with public health to address public safety concerns and develop information used to address important policy issues, and

- Recognizing the efforts and activities of health care providers in exchanging information with public health.

The 2015 Edition Criteria

The Task Force supports the sole use of the 2015 Edition certification criteria for CEHRT beginning January 1st, 2019, discontinuing recognition of the 2014 Edition.

The Task Force believes that CMS should continue to grandfather existing registries that have declared readiness, consistent with *Promoting Interoperability* requirements, until such time a relevant standard is incorporated in the certification criteria. Any standard used should be included in the Office of the National Coordinator's Interoperability Standards Advisory.

We suggest that clarifying language be included in the Final Rule that identifies the exchange standards that can be used by a public health registry or clinical data registry if specifications are not currently specified in the 2015 Edition. This would clarify whether a messaging standard contained in the 2015 Edition may be used for purposes other than its original intent, such as repurposing the message format standard for a cancer registry submission to an alternate purpose.

CMS should also clarify if it intends to consider the Application Programming Interface (API) functionality included in the 2015 Edition as a standard for exchange to meet public health and clinical registry exchange needs. For example, CMS should clarify whether an API established by public health as an interface to a registry meets the appropriate definitions for standards within the 2015 Edition. It should also specify whether such an interface can be used to meet the requirements of the Public Health and Clinical Data Exchange objective within the *Promoting Interoperability* category in QPP. CMS should also specify that any API be open and freely accessible.

Expanding Syndromic Surveillance beyond Urgent Care

The Task Force appreciates the flexibility provided in the proposed rule to allow providers other than those practicing in urgent care settings to receive credit for participating in syndromic surveillance.

Opioid Treatment Agreement (OTA)

The Task Force recognizes the significant challenges presented in managing the opioid crisis across the nation and appreciates CMS' work in developing an approach to assist in managing this ongoing issue. In the Inpatient Prospective Payment System (IPPS) Final Rule, released on August 2nd, 2018, CMS acknowledged that there needs to be ongoing discussion regarding the utility of OTAs, the lack of standards regarding OTAs, and other concerns. The Task Force supports ongoing dialogue, including the identification of relevant content and exchange standards, applicability, and interpretive guidance. Participants in the dialogue should include patients, health care providers, public health, and vendors. Resources to be developed include OTA content, how an OTA should be interpreted by health care providers across all venues, appropriate data structures, and interoperability specifications.

Public Health Registries and Clinical Data Exchange Objective

CMS should clarify that providers may only claim exclusions as a last option, when they cannot identify registries with which they are eligible to participate. The provider should first look to find available registries. Focusing on encouraging participation rather than on claiming exclusions in *Promoting Interoperability* improves information exchange and reinforces applicable state law regarding providing data to public health.

It is important that CMS clarifies in the QPP Final Rule that there is an expectation that health care providers make every attempt to engage with public health for at least the first measure in the objective, and that the second measure could be either a public health or a clinical data registry. Furthermore, any clinical data registry must exchange data with providers from multiple health care organizations. This approach emphasizes the exchange of data beyond a single provider organization, a potential limitation of a clinical data registry operated by a single health care system.

Conclusion

The success of *Promoting Interoperability* should be advanced by the ongoing collaboration between public health and private providers, strengthened by interoperable information systems. This collaboration should focus on approaches that enhance individual patient care and population health goals, reduce provider burden associated with redundant processes and unnecessary activities, and protect the public's health. CMS should remain committed to including public health as a partner in the future of the *Promoting Interoperability* programs and continue to work with stakeholders to advance interoperability.