September 1, 2020

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Proposal to Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule

Attention: CMS-1734-P

Submitted electronically to http://www.regulations.gov

Dear Administrator Verma:

The Sequoia Project is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) on interoperability-related provisions in the annual Medicare physician fee schedule proposed rule, primarily for the Merit-based Incentive Payment System (MIPS). We appreciate CMS's demonstrated record of responding thoughtfully to the comments that it receives on such proposed rules from its many stakeholders.

The Sequoia Project is a non-profit, 501(c)(3) public-private collaborative that advances the interoperability of electronic health information for the public good. The Sequoia Project previously served as a corporate home for several independently governed health IT interoperability initiatives, including the eHealth Exchange health information network and the Carequality interoperability framework. The eHealth Exchange and Carequality now operate under their own non-profit organizations. The Sequoia Project currently supports the RSNA Image Share Validation Program, the Patient Unified Lookup System for Emergencies (PULSE), and the Interoperability Matters Cooperative. Lastly, we are honored to have been selected by the Office of the National Coordinator for Health IT (ONC) to be

the Recognized Coordinating Entity (RCE) for the Trusted Exchange Framework and Common Agreement (TEFCA).

These comments reflect our experience supporting large-scale, nationwide health information sharing, including active work with several federal government agencies. Through these efforts, we serve as an experienced, transparent, and neutral convener of public and private sector stakeholders to address and resolve practical challenges to interoperability. Our deep experience implementing national-level health IT interoperability, including our track record of supporting and operationalizing federal government and private sector interoperability initiatives, provide a unique perspective on the proposed rule.

Overview

The Sequoia Project supports CMS's focus on interoperability and patient access to data and its intention to give providers greater flexibility while reducing their burdens. We also appreciate, as indicated below, proposals aimed at enhancing interoperability and information exchange. We provide suggestions based on our experience. In our comments, we highlight:

- Lessons learned and pertinent best practices from The Sequoia Project and its partner initiatives, including Carequality and the eHealth Exchange;
- The importance of a balanced approach to the various technologies and architectures available for provider-to-provider exchange;
- The similar need for balancing the emphasis on making available, sending, receiving, and integrating data to enhance clinical care, outcomes, and patient experience; and
- Opportunities to lessen complexity, reduce risk to CMS goals, lower regulatory and compliance costs for the federal government, and to ease the burden on providers, exchange, and technology organizations.

Comments on the Interoperability Measures for the Merit-based Incentive Payment System (MIPS)

- **PDMP—**CMS proposes to retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure for CY 2021 and to make it worth 10 bonus points, up from 5 points in CY 2020.

  Comment: The Sequoia Project supports both aspects of this proposal for the reasons stated by CMS. Despite slower than desired progress in integration of PDMPs with EHRs, such integration, including notably the ability to query PDMPs, is very valuable and we believe that CMS strikes the appropriate balance in this proposal.

- **Health Information Exchange (HIE) Objective**

  - CMS proposes a wording change for the "Support Electronic Referral Loops by Receiving and Incorporating Health Information" measure, previously created by combining the "Request/Accept Summary of Care" measure and the "Clinical

Information Reconciliation" measure). CMS proposes to change the term "Incorporating" to "Reconciling" to better reflect actions required by the measure.

Comment: The Sequoia Project supports this proposed change for the reasons stated by CMS and wishes to underscore the importance of this measure for advancing interoperability.

- CMS proposes a new optional alternative measure, "Health Information Exchange (HIE) Bi-Directional Exchange".

  CMS outlines the benefits of HIEs and bi-directional exchange. It also states that, "[i]n addition to these initiatives, many EHR vendors are participating in the development of national-level networks . . . [g]eographically-based exchanges have also begun to address national-level exchange, with efforts designed to link state and regional networks so that health care providers can obtain information on individual patients wherever they receive care throughout the United States. " CMS states that "incentivizing participation in HIEs that support bi-directional exchange will contribute to a longitudinal care record for the patient and facilitate enhanced care coordination across settings." CMS notes also the new Conditions of Participation (CoP) policy related to patient event (ADT) notifications finalized in the recent CMS Patient Access and Interoperability Final Rule and the opportunity to expand beyond the limited data set required for the ADT CoP. Finally, CMS notes the value of bi-directional HIE exchange for the COVID-19 response, including support for enhanced telehealth.

  CMS proposes to add this new measure under the HIE objective beginning with the 2021 performance period. This new measure would be an optional alternative to the two existing measures: "Support Electronic Referral Loops by Sending Health Information" measure and "Support Electronic Referral Loops by Receiving and Incorporating Health Information".

  Clinicians could either report the two existing HIE measures and associated exclusions or the new alternate measure. The new measure would be worth 40 points, the total of the two current measures. The new measure would be reported by attestation, with a yes/no response, rather than tracking and incrementing numerators nd denominators.

  Comment: The Sequoia Project supports the addition of this proposed optional measure for the reasons well-articulated by CMS, the proposed value of 40 points, and the ability to report by attestation rather than tracking and reporting numerators and denominators. The ongoing capability for bi-directional exchange, and use of such a capability, are critical to advancing effective interoperability. The Sequoia Project and its partner initiatives have invested countless hours in furthering development and effective use of such capabilities. As outlined below, we do, however have suggestions for enhancing the terms of

the attestations proposed by CMS to better reflect current approaches to bi-directional interoperability.

CMS proposes that clinicians would attest:

- **I participate in an HIE in order to enable secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period.**

  Comment: We note that CMS uses "HIE" as a noun but does not define this term. Elsewhere in the preamble addressing this proposed measure, CMS uses HIE as a verb as well (e.g., "This engagement supports robust health information exchange without placing burden on the clinician or the patient to be individually accountable to facilitate exchange via multiple (and potentially unknown) point-to-point connections."). (p. 50300)

  We are concerned that a focus on HIEs as a noun, with the term undefined, could exclude organizational models that might not be self-identified or otherwise identified as HIEs but that would meet the intent of this measure, especially with respect to national-level exchange. In addition, participation in a single HIE might not meet the need of the measure to support HIE for "every patient encounter, transition or referral". We believe that the measure should be expanded to "HIEs, exchange frameworks, or other organizations focused on bi-directional health information exchange" In defining HIEs, 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:

  We also note that some HIEs and similar organizations are designed on a query-retrieve model only (versus providers automatically pushing visit summaries after each encounter) and do not automatically create longitudinal patient records, although such records are enabled and, in a sense, available "virtually". We believe that the construction of this first attestation supports such a model in that "secure, bi-directional exchange . . . for every patient encounter, transition or referral" is enabled even though it may not occur in the absence of a specific query.

- **The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners.**

  Comment: CMS states that ". . . we would exclude exchange networks that only support information exchange between affiliated entities, such as health care providers that are part of a single health system, or networks that only facilitate sharing between health care providers that use the same EHR

vendor." We ask CMS to clarify that, if such a provider or vendor-specific network connects with a regional or national exchange framework that enables connection across "a broad network of unaffiliated exchange partners," such a connection would satisfy the attestation. In addition, addressing a question posed by CMS, connection by an HIE with such a regional or national framework would be one way for CMS to "identify those HIEs that can support the widespread exchange with other health care providers".

- I **use the functions of CEHRT for this measure**, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10).

  Comment: CMS notes that there are "numerous certified health IT capabilities which can support bi-directional exchange with a qualifying HIE" (e.g., C-CDA, APIs, USCDI, etc.)" We agree that the applicable functions of CEHRT should be used for this measure but also ask CMS to acknowledge that capabilities used may go beyond what is certified (certification as floor and not a ceiling) and also use technologies that are not subject to certification.

Conclusions

We thank CMS for providing the opportunity to comment on this proposed rule. Again, we strongly support CMS's intention to focus its incentive programs on interoperability and urge CMS to deepen its proposed balanced emphasis on patient access to their data and provider–to-provider exchange, with the latter also facilitating and encouraging provider and other authorized queries of patient information using appropriate standards and trust frameworks.

The Sequoia Project is eager to assist CMS in advancing our national interoperability agenda.

Most respectfully,

Mariann Yeager
CEO, The Sequoia Project