June 22, 2018

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1694–P
P.O. Box 8011
Baltimore, MD 21244–1850

Subject – IPPS and Promoting Interoperability Proposed Rules - Request for Comments

Dear Administrator Verma,

We are writing on behalf of the Association of Public Health Laboratories (APHL) about the Centers for Medicare and Medicaid’s (CMS’s) proposed rules: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims.

APHL represents state and local governmental health laboratories in the United States. APHL members monitor, detect, and respond to health threats. APHL works to strengthen laboratory systems serving the public’s health in the United States and globally. And APHL plays an additional role in public health that is particularly relevant to these rules. APHL operates the APHL Informatics Messaging Services (AIMS) Platform - the pre-eminant public health shared services messaging platform that has been developed with assistance from the Centers for Disease Control and Prevention, the Food and Drug Administration, the Office of the National Coordinator for Health Information Technology and others. The platform supports standards-based data exchange and transformation services for public health and, increasingly, for clinical care organizations seeking to connect to public health agencies nationwide. AIMS currently receives approximately 9 million messages per month and is working with over 160 data exchange partners nationwide.

Because of its unique role in health information exchange, APHL understands interoperability, information exchange between organizations, and what it takes to make health data move nationwide. We have watched some elements of the CMS Meaningful Use program work very well to advance information exchange with public health and some elements that did not work as well. We would like CMS to consider our comments on these proposed rules, below, in the
context of making the new “Promoting Interoperability Programs” criteria successful in advancing interoperability while reducing provider burden.

The “recipe” that has worked nationally to advance interoperability is: 1) strong incentives to exchange data, 2) highly-specified standards for the exchange, and 3) testing to ensure compliance. This recipe has not always been consistently applied, but has been successful when it has. We particularly think that it needs to be applied now, in these measures for the purpose of advancing electronic case reporting (eCR). eCR was only recently added to Meaningful Use and, as such, now needs the strongest incentives for advancement.

eCR was the last public health measure added to Meaningful Use not because it is the least important, but because it has been the most complicated to advance. The complex issues of variable State reporting regulations and sensitive data have made a solution more elusive and standards more difficult to develop. A solution is now in place and consensus-based HL7 national standards have existed for some time. But without strong incentives this core public health activity that is required by law in every state and territory nationwide will either not advance or will advance through individual jurisdiction and program solutions that will be exceedingly burdensome to clinical care and Electronic Health Record vendors.

eCR is now set-up to be advanced as an automated activity that will reduce clinical care burden, but also comport with reporting regulations nationally. Case reporting is the cornerstone of public health surveillance for outbreak management and disease monitoring. In fact, new reporting laws are being actively added in the majority of states because state and local public health agencies understand that case reporting is the most impactful surveillance that can be applied to the current opioid crisis just as it is the most important surveillance process for disease outbreaks such as Zika, Ebola, West Nile, Anthrax, and many others. Case reporting fuels the National Notifiable Disease system to monitor disease trends nationally, but is also central to practical public health response that de-identified data cannot address.

As such:

- Additional incentives, such as bonus points, should be available in these measures to specifically support the critical, developing activity of automated electronic case reporting. There is now nationwide, public-private momentum to solve this complex problem, but CMS needs to do its part to advance strong incentives now at this critical juncture. The other parts of the interoperability ‘recipe”; specific required standards (which exist but are not currently specified in ONC’s certification rule) and testing should also be advanced aggressively now.

- The public health measures overall should not be weakened by changes that make some measures “required” and resultantly minimize other measures’ requirements. These and other formula changes in the proposed rules that weaken, or even fully bypass, critical public health needs should revert to their stronger, previous state.

- Public health measures should not be removed in 2022. Incomplete implementation adds to provider burden. Burden is relieved by recognizing completed activities and not eliminating them. Having some providers report and others not report will not adequately support outbreaks or other national emergencies. Sometimes the importance of these
activities is not highlighted until there is a public health event, but these emergency
events will happen and incomplete implementation will be viewed with close scrutiny.

- Existing measures should not be substituted for by pilots for emerging standards.
  Innovation has value, but, in fact, coalescing and implementing existing standards is a
  critical component of the interoperability “recipe” identified above and is by far the most
  pressing current need. This coalescing would be impeded by this proposed change.

- TEFCA participation should not be included as an activity that would count for credit in
  health information exchange. Public health has been unanimous in pointing out that the
  TEFCA, as currently proposed, would support almost no public health data exchange.
  Public health, and most of clinical care, is based on “unsolicited push” transactions. The
  TEFCA currently only addresses a limited “query” use case. As such TEFCA, despite its
  public health permitted purpose, does not help address the overwhelming majority of
  public health needs.

We do appreciate the inclusion of public health measures in these rules and also the opportunity
for public health agencies to get 90/10 matching funds, but this work is not done and these
incentives should persist. At a time when so many seek interoperability and a well-functioning
clinical care and public health system, strong incentives for public health and its core capability
of electronic case reporting should be strengthened – not weakened or eliminated.

With best regards,

Scott Becker, MS
Executive Director