AIRA
AMERICAN IMMUNIZATION REGISTRY ASSOCIATION

June 17, 2022

Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Health and Human Services Department
Attention: CMS-1771-P, P.O. Box 8013
Baltimore, MD 21244

RE: **Medicare Program; 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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation**

Dear Ms. Brooks-LaSure,

On behalf of the American Immunization Registry Association (AIRA) we are pleased to submit comments on the Centers for Medicare and Medicaid Services recently released documents related to proposed changes specifically in the **Medicare Program; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals.** These comments are a compilation of the input of our members which include over 80 organizations representing Public Health Immunization Information Systems (IIS), IIS implementers and vendors, non-profit organizations and partners. Immunization Information Systems exchange data with a broad range of stakeholders, including providers, pharmacists, schools, child care facilities, health plans and payers, among others.

IIS and our partners are invested in promoting smooth interoperability to ensure complete data capture and broad data use. The COVID-19 pandemic response has shined a spotlight on the critical importance of public private data exchange and broad data use. IIS play a critical role in consolidating longitudinal immunization records across disparate clinical sites for individuals within a catchment area, and making them available as needed. At the point of clinical care, an IIS provides consolidated immunization records and forecasts recommended vaccines to support clinical decisions. At the population level, an IIS provides aggregate data and information on vaccinations for surveillance, program operations and public health action. It is critical that the role of Public Health is recognized as a key part of health IT strategy moving forward.

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To that end, we are writing to strongly support the proposed CMS changes to establish new requirements and revise existing requirements for eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program.

AIRA provides additional suggestions on the specific requests for information outlined in the draft document; these comments are presented on the following pages, organized by section where appropriate.

We greatly appreciate the opportunity to comment on these draft changes, and we enthusiastically support the recommendations outlined in the proposed rule. We look forward to continuing to collaborate with CMS to ensure high-value health IT interoperability with our many partners. Please feel free to contact me with any questions: mbkurilo@immregistries.org.

Sincerely,

Mary Beth Kurilo, MPH, MSW
Senior Director of Health Informatics
American Immunization Registry Association (AIRA)

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Comments: Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals, 2022

Section and page number (where relevant)	Excerpt	Comment
Printed page 28588	*During the recent COVID-19 PHE, we recognized the importance of public health reporting (as discussed further in section IX.H.5. of this proposed rule), and we believe that knowing the level of active engagement that an eligible hospital or CAH selects would provide information on the types of registries and geographic areas with health care providers in the Pre-production and Validation stage.*	We support eligible hospitals and CAHs having a reporting requirement to communicate their stage of active engagement. This visibility will increase focus on progress and momentum for creating interfaces, and will also allow transparency at the nation-wide level as connectivity progresses.

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Section and page number (where relevant)	Excerpt	Comment
Printed page 28588	*As we are now proposing to require eligible hospitals and CAHs to submit their level of active engagement for each measure they report, we are also proposing, beginning with the EHR reporting period in CY 2023, that eligible hospitals and CAHs may spend only one EHR reporting period at the Pre-production and Validation level of active engagement per measure, and that they must progress to the Validated Data Production level for the next EHR reporting period for which they report a particular measure.*	We support the proposed change that eligible hospitals and CAHs are allowed to stay in testing (stage 2) for only one reporting period. This will ensure participants remain focused and maintain momentum in the testing process.
Printed page 28588	*Eligible hospitals and CAHs must demonstrate their level of active engagement as either proposed Option 1 (pre-production and validation) or proposed Option 2 (validated data production) to fulfill each measure. We are inviting public comment on these proposed changes to the options for active engagement.*	We disagree with the proposal to combine current options 1 and 2 for meeting active engagement ("completed registration to submit data" and "testing and validation") into one category. Although combining these may promote a greater incentive to move through the testing process quickly and efficiently, it also obscures the granularity of where eligible hospitals and CAHs are in the process of onboarding with public health programs. Maintaining the three distinct categories will allow transparency into the process.

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Section and page number (where relevant)	Excerpt	Comment
Printed page 28589	*Specifically, if an actor is required to comply with another law that relates to the access, exchange, or use of EHI, failure to comply with that law may implicate the information blocking regulations. As an example, where a law requires actors to submit EHI to public health authorities, an actor's failure to submit EHI to public health authorities could be considered an interference under the information blocking regulations.*	We support this change to interpret a lack of reporting as potential information blocking. In the absence of a broad policy to incentivize immunization reporting, some provider sites and the systems that support them will opt not to prioritize data exchange. The possible interpretation of non-reporting as information blocking may support all parties more quickly prioritizing data exchange, which helps providers, public health, and most importantly, consumers in ensuring complete and accurate consolidated immunization records.

Section and page number (where relevant)	Excerpt	Comment
Printed page 28590	*The Public Health and Clinical Data Exchange Objective, with its current four required measures, is currently worth only 10 points. Despite increasing the number of required measures from two to four to make the objective more effective in promoting public health data electronic exchange, the total number of points did not change between CY 2021 and CY 2022. We believe that increasing the point value of the Public Health and Clinical Data Exchange Objective would create a more meaningful incentive for eligible hospitals and CAHs to engage in the electronic reporting of public health information and recognize the importance of public health systems affirmed by the COVID-19 pandemic.*	We support increasing the points associated with public health reporting measures. As the document states, COVID-19 pandemic has highlighted the criticality of public health reporting. Increasing the point value for public health reporting would make the Public Health and Clinical Data Exchange Objective a more central piece of the Promoting Interoperability Program and better incentivize eligible hospitals and CAHs to implement these essential public health data exchange capabilities.