June 13, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1677-P

Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, etc.

Dear Administrator Verma,

The Medical Group Management Association (MGMA) is supportive of physician practice adoption of health information technology (HIT) and the use of HIT to deliver high-quality patient care. MGMA appreciates the opportunity to provide comments on the Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, advocacy and education, MGMA empowers medical group practices to create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents 18,000 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

The objective of HIT is to improve healthcare quality, control growth in costs, enhance the efficiency of healthcare administration, stimulate innovation and ensure the privacy and security of patient information. The overarching goals of the Centers for Medicare & Medicaid Services (CMS) and the office of the National Coordinator for Health Information Technology (ONC) should be to develop a flexible set of supporting regulations with the goal of improving the nation's healthcare delivery system while meeting statutory mandates. We assert that in order to fulfill these objectives, the Meaningful Use Incentive Program requirements must be achievable and verifiable

without creating an undue burden on eligible professionals (EPs) and their administrative staff.

We have grown increasingly concerned regarding the government overreach with respect to the Meaningful Use Incentive Program. The previous Administration produced a regulatory environment that is clearly contrary to the intent of the originating statute and served to distract clinicians from patient care and stifle vendor innovation. We hope that these comments on the IPPS proposed rule will serve as a guidepost for improving the Meaningful Use Incentive Program, the Merit-Based Incentive Payment System (MIPS), and the advanced Alternative Payment Model (APM) program going forward.

Overview of MGMA Recommendations

- Eliminate Stage 3 of the Meaningful Use EHR Incentive Program
- Permit 2014 CEHRT to be used in the Meaningful Use EHR Incentive Program until the program is finished (and permit its use in MIPS and APMs for the foreseeable future)
- Permit an EP, participating in the Medicaid EHR Incentive Program, the option to opt out of participation in MIPS or earn automatic full Advancing Care Information score
- Establish a blanket hardship exception for all eligible professionals (EPs) subject to the 2018 Meaningful Use EHR Incentive Program negative payment adjustment as these clinicians will be transitioning to MIPS/APMs
- Support the creation of a hardship exception for EP who have their EHR decertified, but do not require that these EPs immediately purchase new software
- Support the exclusion of EPs from the Meaningful Use EHR Incentive Program who practice in an ambulatory surgical center, but urge the threshold be reduced set at 51 percent
- Expand the number of Place of Service codes that define “hospital-based”
- Leverage the 21st Century Cures Act of 2016 to improve the EHR certification process

Comments on Regulatory Provisions

Issue: Alignment of CQMs for Medicaid EPs with those updated annually for MIPS (page 20134-5)

Specifically, we are proposing that the CQMs available for Medicaid EPs in 2017 would consist of the list of available CQMs for reporting from an EHR for MIPS in 2017, available in the Appendix of the CY 2017 Quality Payment Program final rule with comment period under Table A, which are denoted with a CMS e-Measure ID number.

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In the CY 2017 Quality Payment Program final rule with comment period (81 FR 77145), we noted that one commenter requested that we engage State Medicaid leaders to maximize measure alignment across Medicare and Medicaid. We responded that we intend to align quality measures among all CMS quality programs where possible, including Medicaid, and would take this comment into account in the future. In addition, States have requested alignment between the CQM set for MIPS and the CQM set for EPs in the Medicaid EHR Incentive Program for consistency and convenience, to reduce burden, and to avoid confusion. In addition, we believe it is more likely that professionals would participate in both programs if the CQM sets are aligned. While participation in MIPS is required for professionals who are considered "MIPS eligible clinicians," participation in the Medicaid EHR Incentive Program is not required. If the CQMs are not aligned across both programs, we believe it is less likely that MIPS eligible clinicians would also participate as EPs in the remaining years of the Medicaid EHR Incentive Program.

Finally, as noted above, the CQMs that were removed from MIPS (81 FR 77773, Appendix, Table F) had not been updated and were no longer clinically relevant, and we believe that the revised list of CQMs would better reflect updated clinical standards and guidelines (81 FR 77144). We anticipate that this proposal would reduce burden for Medicaid EPs, and that the systems changes that would be needed to implement it would not be significant for either States or EPs. The set of 53 CQMs available to MIPS participants is a subset of the 64 CQMs currently available under the Medicaid EHR Incentive Program. In addition, we believe that if EPs also plan to participate in MIPS, they should already be prepared to report on the 53 CQMs. However, we welcome comments on whether any EPs might be negatively affected by the proposal; for example, on whether any EPs might have EHRs that do not measure enough of the 53 remaining CQMs because they were relying on some of the 11 CQMs that would be removed. We do not anticipate that this would be a common situation because these 11 CQMs are outdated, and the industry is moving away from them as EHRs are upgraded to meet the MIPS requirements.

MGMA comment

We appreciate CMS addressing this issue and support the agency's proposal to align CQMs for Medicaid EPs with those updated annually for MIPS. It is important to note that a substantial number of medical groups will employ some EPs that participate in their state's Medicaid Meaningful Use Incentive Program, while at the same time other EPs in the group will be participating in MIPS. CMS should not require these groups to develop and implement two entirely separate data capture workflows. Requiring two separate workflows most likely would force the practice to incur the cost of additional software upgrades, staff training, and ongoing administrative overhead. We also agree with the assertion in the proposed rule that if the CQMs are not aligned across both programs, it is less likely that MIPS eligible clinicians would also participate as EPs in the remaining years of the Medicaid EHR Meaningful Use Incentive Program. We also support the agency's decision to update the list of CQMs available for use in the Medicaid Meaningful Use Incentive Program to reflect the CQMs removed as part of

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MIPS. We do remain concerned that some EHR vendors may not support the full complement of 53 measures and urge CMS to survey the EHR environment to ascertain whether or not vendors are supporting all available CQMs.

Issue: New hardship exception for decertified EHRs (page 20137)

We are proposing to revise §495.102(d) to add a new exception for EPs who demonstrate through an application process that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by the EP has been decertified under ONC's Health IT Certification Program. We are proposing this exception for the CY 2018 payment adjustment year, which is the final year of the payment adjustment for EPs under section 1848(a)(7)(A) of the Act. We considered but are not proposing this exception also for the CY 2017 payment adjustment year because it would require us to reprocess claims for potentially the entire CY 2017, which would be costly and administratively burdensome. ONC provides that there is a 6-step process that usually occurs when implementing a certified EHR technology system. We believe that if an EP has to procure new certified EHR technology they will likely have to go through some phases of this cycle again and understand that it would be time consuming and may take up to a year to implement.

We are proposing an EP may qualify for this exception if their certified EHR technology was decertified either before or during the applicable EHR reporting period for the CY 2018 payment adjustment year, which under §495.4 is any continuous 90-day period in CY 2016 or 2017, depending on whether the EP has successfully demonstrated meaningful use in a prior year. If the certified EHR technology was decertified at any time during the 12- month period preceding the applicable EHR reporting period for the CY 2018 payment adjustment year, or during the applicable EHR reporting period for the CY 2018 payment adjustment year, the EP may qualify for this exception. For example, if an EP intended to attest to meaningful use for a 90-day EHR reporting period beginning on April 1, 2016, the EP could apply for this exception if their certified EHR technology was decertified at any time during the 12-month period beginning on April 1, 2015 and ending on March 31, 2016, or if their certified EHR technology was decertified at any time during their 90-day EHR reporting period beginning on April 1, 2016. We believe a 12-month period is reasonable because we understand the burden placed on EPs related to time and funds needed to purchase and deploy new certified EHR technology including the process that goes along with implementing new certified EHR technology. In addition, we are proposing that the EP must demonstrate in its application and through supporting documentation if available that the EP intended to attest to meaningful use for a certain EHR reporting period and made a good faith effort to adopt and implement another CEHRT in advance of that EHR reporting period. We are proposing an EP seeking to qualify for this exception would submit an application in the form and manner specified by us by October 1, 2017, or a later date specified by us.

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MGMA comment

While we are fully supportive of adding a new hardship exception for EPs based on their EHR being decertified, we have some concerns regarding the specifics of the application process outlined in the proposed rule. We assert that EPs should be afforded considerable latitude regarding their application for a hardship exception when experiencing the decertification of their EHR. For example, while we agree that the EP should be required to attest that they had intended to meet the Meaningful Use Incentive Program requirements for the reporting year, we oppose the proposal that the EP make a good faith effort to adopt and implement another CEHRT in advance of that EHR reporting period. It is unreasonable to require an EP to virtually immediately discard their current decertified EHR and install an all new EHR. It should be noted that just because an EHR software product has been decertified by the Office of the National Coordinator for HIT (ONC) does not mean it will be unusable by the practice and unsafe for patients.

Further, moving to another software product will require significant financial investment on the part of the EP, typically tens of thousands of dollars per EP. Multiple vendor products must be carefully evaluated and demonstrated. New software must then be configured to meet the needs of practice clinicians, and practice workflows must be completely transformed. Further, and perhaps most challenging, patient data must be transferred from one system to another—very difficult in the best of circumstances, almost impossible if the old vendor is less than fully supportive of the transition. With no federal requirements on vendors to support this data interoperability from one product to another, many practices are forced to employ a manual process involving printing and scanning the old files into a PDF format and then uploading these to the new software. Thus, EPs experiencing decertification need considerably more time to make the transition to a new CEHRT product than the proposed rule's 12 months. We recommend that EP have no requirement to move to a new CEHRT product and, at a minimum, no less than 3 years be afforded to EPs to make the switch.

In addition, we urge the agency to extend the time EPs have to submit a hardship exception for decertification of a CEHRT product to December 31 of the reporting year.

Regulatory issue: Program exclusion for EPs practicing in an ASC (page 20138)

We are proposing to define an ASC- based EP under §495.4 as an EP who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an ASC setting in the calendar year that is two years before the payment adjustment year. The percentage of covered professional services in this proposed definition is the same as our definition of a hospital-based MIPS eligible clinician under the Quality Payment Program (§414.1305 and 81 FR 77238 through 77240). In the alternative, we are proposing to define an ASC-based EP as an EP who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an ASC setting in the calendar year that is two years before the payment adjustment year. The percentage of covered professional services in this

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alternative proposal is the same as our definition of a hospital-based EP for the EHR Incentive Programs (§495.4 and 75 FR 44439 through 44442). Under these proposals, we would use claims for services furnished in CY 2015 to determine whether an EP is ASC-based for the CY 2017 payment adjustment year, and we would use claims for services furnished in CY 2016 to determine whether an EP is ASC-based for the CY 2018 payment adjustment year. We are also proposing to use Place of Service (POS) code 24 to identify services furnished in an ASC and are requesting public comment on whether other POS codes or mechanisms to identify sites of service should be used in addition to or in lieu of POS code 24.

MGMA comment

MGMA is fully supportive of granting EPs who practice in ASCs a hardship exception to avoid being unfairly penalized. We do believe, however, that the two proposals, a 75 percent threshold and a 90 percent threshold, would each impose an unfairly high threshold on clinicians practicing in these settings. We recommend the threshold be established at 51 percent. This meets the MACRA requirement that the clinician practice the majority of their care in an ASC and better reflects the challenges that an EP faces in meeting program requirements when practicing the majority of their care in a clinical setting that is not recognized as a participating site of service under the Meaningful Use EHR Incentive program.

Issue: Place of service codes to define "hospital-based" clinicians (page 20139)

The percentage of covered professional services in this proposed definition is the same as our definition of a hospital-based MIPS eligible clinician under the Quality Payment Program (§ 414.1305 and 81 FR 77238 through 77240).

MGMA comment

A hospital-based EP is defined under the Meaningful Use Incentive Program as an EP who furnishes 90 percent or more of their covered professional services in either the inpatient (POS 21) or emergency department (POS 23) of a hospital. We recommend that, for purposes of determining if an eligible clinician is "hospital-based" under MIPS, the list of POS codes should be expanded. POS 19, "Off-Campus Outpatient Hospital and POS 61 "Comprehensive Inpatient Rehabilitation Facility" appear to be consistent with POS 22 and 21 respectively (included in the current MIPS definition of "hospital-based") and thus should be added to the definition.

Regulatory Issue: Requirement for 2015 Certified EHR Technology (page 20138)

In the 2015 EHR Incentive Program final rule (80 FR 62871 through 62875), we adopted a final policy regarding which Edition of CEHRT must be used by EPs, eligible hospitals, and CAHs for the EHR Incentive Program, which is reflected in the definition of CEHRT §495.4. At a minimum, EPs, eligible hospitals, and CAHs would be required

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to use EHR technology certified to the 2014 Edition certification criteria for their respective EHR reporting periods in 2015 through 2017. They may also upgrade to the 2015 Edition to meet the required certified EHR technology definition for the EHR reporting periods in 2015, 2016, or 2017, or they may use a combination of 2014 and 2015 Editions if they have modules from both editions that meet the requirements for the meaningful use objectives and measures or if they fully upgrade during an EHR reporting period. Starting with 2018, all EPs, eligible hospitals, and CAHs would be required to use technology certified to the 2015 Edition to demonstrate meaningful use for an EHR reporting period in 2018 and subsequent years (80 FR 62873 through 62875). We received comments on the Stage 3 proposed rule requesting that we allow health care providers to use the 2014 and 2015 Editions of CEHRT in 2018 (80 FR 62874 through 62875). We also received feedback from EPs, eligible hospitals and hospital associations after the 2015 EHR Incentive Program final rule was published. The feedback expressed concerns regarding the burden that will likely occur as a result of the new functionalities required in the implementation of the Stage 3 requirements including an increase in the cost of care without better patient outcomes. Based on our past experience with the transition from the 2011 Edition to the 2014 Edition and concerns expressed by stakeholders, we understand that transitioning to technology certified to a new Edition can be complex and can require more resources and time than anticipated, including the time necessary to effectively deploy the upgraded system and make the necessary patient safety, staff training and workflow investments. We understand and appreciate these concerns, and are working in cooperation with our Federal partners at ONC to monitor progress on the 2015 Edition upgrade.

Furthermore, we believe that there are many benefits for switching to EHR technology certified to the 2015 Edition. At this time, our analysis shows that progress toward certification and upgrade of systems should enable EPs that attest directly to a State for the State's Medicaid EHR Incentive Program and eligible hospitals and CAHs attesting to CMS or the State's Medicaid EHR Incentive Program to upgrade systems to the 2015 Edition and successfully attest for an EHR reporting period in 2018. We will work with ONC to monitor the deployment and implementation status of EHR technology certified to the 2015 Edition.

If we identify a change in the current trends and significant issues with the certification and deployment of the 2015 Edition, we will consider flexibility in 2018, for those EPs that attest directly to a State for the State's Medicaid EHR Incentive Program and eligible hospitals and CAHs attesting to CMS or the State's Medicaid EHR Incentive Program that are not able to implement 2015 Edition CEHRT to attest for an EHR reporting period in 2018. One possibility is the flexibility to use technology certified to the 2014 Edition or the 2015 Edition for an EHR reporting period in 2018. Another option is allowing a combination of EHR technologies certified to the 2014 Edition and 2015 Edition to be used for an EHR reporting period in 2018, for those EPs, eligible hospitals, and CAHs that are not able to fully implement EHR technology certified to the 2015 Edition. We are inviting public comment on these options for offering flexibility in CY 2018 with regard to EHR certification requirements.

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MGMA comment

Our member practices are very concerned with the unrealistic timeframe and the difficult-to-meet requirements laid out in Stage 3 of the Medicaid Meaningful Use Incentive Program, as well as with the related requirements under MIPS. The Office of the National Coordinator for Health Information Technology (ONC) adopted an EHR software certification methodology that forced vendors to direct research and development resources to meeting arbitrary government requirements and away from implementing end user-friendly design. This regulatory-focused software certification environment has resulted in lost productivity, additional cost for practices to retool software to better meet their clinical and administrative needs and arguably had a negative impact on patient interactions. As a result of these and other potential patient care-related challenges, we recommend that Stage 3 of the Meaningful Use Incentive Program be eliminated.

We also believe that the following assertion in the proposed rule is incorrect: "…*our analysis shows that progress toward certification and upgrade of systems should enable EPs that attest directly to a State for the State's Medicaid EHR Incentive Program and eligible hospitals and CAHs attesting to CMS or the State's Medicaid EHR Incentive Program to upgrade systems to the 2015 Edition and successfully attest for an EHR reporting period in 2018."* It is important to note that, as of this writing, only about two percent (72) of EHRs have been certified to the 2015 Edition compared with the number which have been certified for the previous 2014 version (3,711) now in use. Since the 2015 Edition is required for use in 2018 by providers for Stage 3 and MIPS, it is extremely unlikely that a large majority of EHR software vendors will be able to deliver the systems in time for providers to test and deploy them by January 1, 2018. Without these systems in place and tested well before the start of a reporting period, providers face rushed implementations which may jeopardize patient safety coupled with the potential for substantial financial penalties.

With the passage of the Medicare Access and CHIP Reauthorization Act, many providers are transitioning to MIPS and advanced APMs. To facilitate a smooth transition, we believe more time is needed to offer stability to the clinicians using CEHRT and to enable vendor innovation in the marketplace. Further, the existing timelines, which require providers to implement 2015 Edition CEHRT by January 1, 2018 do not take into account the important improvements included in the bipartisan 21st Century Cures Act. Providers will not have the opportunity to benefit from several provisions aimed at improving the use of EHRs, including efforts to reduce the regulatory burden and improvements to the usability of CEHRT.

There is also tremendous concern regarding the timing of any announcement regarding expanded CEHRT flexibility. In several occasions under the previous Administration, major modifications were made to the Meaningful Use Incentive Program that required changes to EHR software. Yet these program modifications were made very late in the reporting year—making it next to impossible for providers and their vendor partners to successfully meet program requirements. In order for providers to make appropriate adjustments in a timely manner, we strongly recommend that CMS formally notify providers of a delay in the required use of 2015 Edition CEHRT as soon as possible and

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not wait until publication of the final rule in the fall or winter.

General Comments

Improving the EHR certification process and implementation of CURES

As HHS moves forward with implementation of the 21st Century Cures Act of 2016, we urge the Department to take the opportunity to significantly modify the EHR certification process and requirements to improve the alignment of technology with clinical practice and better support the delivery of high-quality care. Currently ONC certifies that EHRs are able to meet a low-bar of requirements directly related to CMS' reporting program. To further laudable and achievable industry interoperability goals, ONC needs to significantly overhaul its certification program. Most importantly, ONC should modify its certification program to validate that EHR software not only meets established interoperable standards and quality reporting program requirements, but more importantly, contains the functionality necessary to support the real-world needs of clinicians.

To assist in the development of a clinician-focused EHR software certification process, all FACA advisory committees must include appropriate representation from practicing physicians from a wide variety of clinical settings, including small practices, as well as administrative leaders managing medical group practices.

EHR pricing transparency and restricting data blocking

In addition to the significant investment physician practices make in their EHR systems, vendors often require additional fees to connect those EHRs to registries, information exchanges, and public health agencies. While ONC requires EHR vendors to reveal that extra charges may be required, the dollar amounts are not released to the public. Many EHR vendors overly generalize costs and are not upfront with physician practices during the contracting process. Physician practices of all sizes will be particularly hard hit by this unfair business practice. Connectivity fees are often unexpected and in many cases overly excessive. These fees can serve essentially as a roadblock to the effective and efficient exchange of critical patient data and limit the interoperability between EHR systems. Consequently, the government should require vendors seeking certification to publicly-provide detailed examples of fees (including dollar figures) typically charged to physicians and options available to enable data sharing.

Similarly, eligible clinicians participating in MIPS or an advanced APM are required to attest to a multipart attestation on data blocking. At the same time, EHR vendors themselves face few restrictions on data-blocking activities. We assert that in many instances, actions related to vendor implementing a combination of cost, technical, or contractual limitations serve to block the interoperability of patient information. We recommend that the government implement a vendor data-blocking attestation

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requirement as part of all current and future health information technology certification editions.

Additional hardship exception for EPs in 2016

With clinicians moving to MIPS or advanced APMs starting this year, we recommend that the agency offer a hardship exception for all EP who were unsuccessful in meeting the 2016 Meaningful Use Incentive Program requirements but plan to transition to either of these new MACRA programs. As MIPS is significantly different than Meaningful Use, clinicians have had to prepare their practice's technology and workflow processes to accommodate this new set of requirements. Transitioning to an advanced APM also necessitates extensive modifications to workflow, communications, and technology. Both programs will require practices to invest human and financial resources to ensure successful participation. In recognition of the challenges and costs clinicians faced in 2016 to move to MIPS and advanced APMs in 2017, we urge CMS to forego penalizing EPs in 2018 for 2016 participation in the Meaningful Use Incentive Program by offering a hardship exception.

To appropriately accommodate clinicians seeking to apply for this hardship exception, we recommend that the standard deadline of July 1 be extended to, at a minimum, Oct. 1, 2017, with Dec. 31, 2017 the preferred deadline.

Continued monitoring of the EHR marketplace

We encourage the close monitoring of the EHR marketplace to ensure that appropriate and cost-efficient products are being offered in a timely manner to physician practices. We also encourage the early recognition of marketplace failures and subsequent requirement for the deployment of low-cost alternative software.

We recommend that CMS, in partnership with ONC, aggressively and comprehensively monitor the industry to ensure: (a) there are sufficient certified EHR products to meet the needs of all segments of the provider industry; (b) bottlenecks and order backlogs caused by delayed software development or certification are not preventing clinicians from obtaining and implementing appropriate products in a timely manner; (c) vendors of complete EHRs and EHR modules that have been certified for 2014 will be certifying for the 2015 edition, or whatever revised certification is developed, and (d) product pricing is not preventing large numbers of clinicians from participating in reporting programs. In addition, we urge HHS to aggressively scrutinize the EHR vendor sector, establishing toll-free telephone numbers and a website allowing physician practices and others to report problems, issues and unfair business practices.

We thank you for the opportunity to provide comment on the important set of issues related to the EHR Incentive Program contained in the 2018 IPPS proposed rule. We look forward to continuing to work with you and others at HHS to advance constructive

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solutions to improve the healthcare delivery process. Should you have any questions, please contact Robert Tennant, Director, HIT Policy, Government Affairs, at rtennant@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders M. Gilberg
Senior Vice President, Government Affairs

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