June 21, 2018

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

RIN 0938–AT27

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 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

Dear Administrator Verma,

The Medical Group Management Association (MGMA) appreciates the opportunity to provide comments on the Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule. Our comments will focus on the health information technology (HIT) proposals in the IPPS proposed rule. MGMA is supportive of physician practice adoption of HIT and the use of HIT to deliver high-quality patient care.

Since 1926, MGMA has been the premier association for professionals who lead medical practices. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

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 (renamed the "Promoting Interoperability" program) requirements must be achievable and verifiable without creating an undue burden on providers.

We have grown increasingly concerned regarding the government overreach with respect to EHR incentive programs. The previous Administration produced a regulatory environment that was clearly contrary to the intent of the originating statute and served to distract clinicians from patient care and stifle vendor innovation. We hope these comments on the IPPS proposed rule will serve as a guidepost for improving all EHR incentive and quality reporting programs.

Comments on Regulatory Provisions

Requirement for 2015 Certified EHR Technology (CEHRT) (pages 20516-20517)

"Beginning with the EHR reporting period in CY 2019, the 2015 Edition of CEHRT is required pursuant to the definition of CEHRT under § 495.4. We are not proposing to change this policy, and, as discussed below, we continue to believe it is appropriate to require the use of 2015 Edition CEHRT beginning in CY 2019. In reviewing the state of health information technology, it is clear the 2014 Edition certification criteria are out of date and insufficient for provider needs in the evolving health IT industry.

As of the beginning of the first quarter of CY 2018, ONC confirmed that at least 66 percent of eligible clinicians and 90 percent of eligible hospitals and CAHs have 2015 Edition available based on previous EHR Incentive Programs attestation data. Based on the data, and as compared to the transition from 2011 Edition to 2014 Edition, it appears that the transition from the 2014 Edition to the 2015 Edition is on schedule for the EHR reporting period in CY 2019."

MGMA comment

MGMA member practices are concerned with the unrealistic timeframe and the difficult-to-meet requirements proposed for the 2019 reporting year of the Medicaid Meaningful Use Incentive (Promoting Interoperability) Program, as well as with the potential related requirements under the Merit-based Incentive Payment System (MIPS). ONC adopted an EHR software certification policy in 2011 that forced vendors to direct research and development resources toward 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.

We also believe the following assertion in the proposed rule is incorrect: "…*our analysis shows that progress toward certification and upgrade of systems should enable [eligible professionals (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 2019."* Moving from 2014 Edition CEHRT to 2015 Edition CEHRT will be an onerous, costly, and challenging process for physician practices. EHR vendors are not required by law to recertify and MGMA remains concerned that a significant percentage of the currently-certified products will not be recertified to the 2015 Edition standard given the substantial costs associated with developing, testing and rolling out this new product to customers.

Further, we contend the government's estimate of practice full adoption of 2015 Edition CEHRT by 2019 is overly optimistic and flawed. ONC's own calculations indicate that only 66 percent of eligible clinicians have moved to 2015 CEHRT, with the remainder most likely being those currently using software that the vendor has not (and may not) recertify to the 2015 Edition, or lack the resources to upgrade their current version to the 2015 Edition. It is important to note that, as of this writing, and based on data contained in the ONC Certified Health IT Product List, only 345 EHR products have been certified to the 2015 Edition compared with the 2,476 products now in use that have been certified for the 2014 Edition. Note that the 345 EHR products certified at the 2015 Edition level is only a modest increase from the approximately 100 2015 Edition certified products at this time last year.

It is unlikely that all EHR software vendors will be able to deliver systems in time for providers to test and deploy them by Oct.1, 2019, the start of the final 90-day reporting period for the year. Without these systems in place and tested well before the start of a reporting period, providers face rushed implementations which increases the potential for substantial financial penalties, reduces administrative efficiencies gained through the use of HIT, and may jeopardize patient safety.

Finally, should you adopt our recommendation to gradually implement the requirement to move to 2015 Edition CEHRT, we strongly urge you announce this flexibility as soon as feasible. On 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 practices and their vendor partners to take advantage of the flexibility 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 not wait until publication of the final rule in the late fall or early winter.

Proposed Revisions to the EHR Reporting Period in 2019 and 2020 (pages 20517-20518)

"For the reasons discussed earlier, we are proposing the EHR reporting periods in 2019 and 2020 for new and returning participants attesting to CMS or their State Medicaid agency would be a minimum of any continuous 90-day period within each of the calendar years 2019 and 2020. This would mean that EPs that attest to a State for the State's Medicaid Promoting Interoperability Program and eligible hospitals and CAHs attesting to CMS or the State's Medicaid Promoting Interoperability Program would attest to meaningful use of CEHRT for an EHR reporting period of a minimum of any continuous 90-day period from January 1, 2019 through December 31, 2019 and from January 1, 2020 through December 31, 2020, respectively."

MGMA comment

We support the proposal in the rule establishing a reporting period of any 90 consecutive days in CY 2019 and CY 2020. We recommend permanently shortening the minimum reporting period to any 90 consecutive days A 90-dayreporting minimum reduces the administrative burden of collecting and reporting EHR data and aligns with the Promoting Interoperability reporting period in MIPS. A shorter reporting period may also allow the agency to shrink the problematic two-year lag between performance and payment, and increase the timeliness and relevance of feedback, which could be provided on a quarterly basis.

Patient Access and Application Programming Interfaces (APIs) (page 20517)

"We continue to receive feedback from EPs, eligible hospitals, hospital associations, and other clinical associations indicating that additional time will be necessary for testing and implementation of the new API functionality requirement for Stage 3. These organizations cite both an inability to meet the required timeframe for implementation of Stage 3 and the complexity of the new functionality and associated requirements for the Patient Electronic Access to Health Information (80 FR 62841 through 62846) and Coordination of Care Through Patient Engagement (80 FR 62846 through 62852) objectives."

MGMA comment

While APIs have the potential to facilitate the exchange of clinical data between providers and their patients, we do not believe that use of APIs is widespread. Mandating their use would prove very burdensome and challenging to many provider organizations. With few development standards currently in place and growing concern regarding the security of these applications, it is premature to require their use as part of the Stage 3 or Promoting Interoperability programs. Moving forward with API technology would require a significant investment of time, money, and human resources for provider organizations. In addition, these required investments, coupled with the security risk associated with this new technology, could result in the unintended consequence of provider organizations determining that it would be in their best interest not to participate in the incentive program.

We recommend that the deployment of API technology not be required in 2019 or 2020 and that CMS and ONC create a voluntary program to evaluate (i) the resources required by a provider organization to deploy API technology; (ii) security issues related to API deployment; and (iii) the impact of APIs on patient access to their health information.

Timeline for Adoption of Promoting Interoperability (PI) Program Performance Measures (page 20519)

"To accomplish our goal of a performance-based program that reduces burden while promoting interoperability, and taking into account the feedback from our stakeholders, we outline a proposal using a performance-based scoring methodology in the following sections of this proposed rule. We believe the proposal promotes interoperability, helps to maintain a focus on patients, reduces burden and provides greater flexibility. The proposal takes an approach that weighs each measure based on performance, and allows eligible hospitals and CAHs to emphasize measures that are most applicable to their care delivery methods, while putting less emphasis on those measures that may be less applicable. If we do not finalize a new scoring methodology, we would maintain the current Stage 3 methodology with the same objectives, measures and requirements, but we would include the two new opioid measures proposed in section VIII.D.6.b. of the preamble of this proposed rule, if finalized."

MGMA comment

We are concerned this proposed timeline for the adoption of performance measures in 2019 and 2020 may unfairly penalize small, rural-based providers who have limited resources to adopt new technologies. The rule outlines one proposed set of measures for the 2019 reporting year, a slightly revised set of measures for the 2020 reporting year, and yet a third option of adopting an enhanced Stage 3 set of requirements, should the first two not be finalized. We strongly caution against implementing Stage 3 objectives, measures, and requirements for the 2019 reporting year, only to mandate providers move to the different Promoting Interoperability requirements in 2020. This would necessitate a complete retooling of software and workflow and drain limited resources that would be better allocated toward improving interoperability. Additionally, as none of these proposals will be finalized until late this year, we urge the agency to offer flexibility to providers seeking to be successful in the program.

Adding this flexibility, having the ability of avoiding the necessity of moving providers to a more stringent set of EHR Incentive Program requirements, was afforded in section 50413 of the Bipartisan Budget Act of 2017 (H.R. 1892). With the intent of Congress clear, we strongly

encourage CMS to permit providers the flexibility to use any of the following approaches for the 2019 and 2020 reporting years:

- Meet the requirements of the Modified Stage 2 program in place for the 2018 reporting year;
- If finalized, meet the requirements in the proposed performance-based scoring methodology for EHR reporting periods in 2019 (pages 20522-20533);
- If finalized, meet the requirements in the proposed performance-based scoring methodology for EHR reporting periods in 2020 (page 20533); or
- Meet the Stage 3 objectives, measures, and requirements including the two new opioid measures: verify opioid treatment agreement and query of prescription drug monitoring program (page 20524).

Medicaid EPs and Policy Options (page 20537)

"Similarly, we also request public comment on whether we should modify the objectives and measures for eligible professionals (EPs) in the Medicaid Promoting Interoperability Program in order to encourage greater interoperability for Medicaid EPs. We are interested in policy options that should be considered, including the benefits of greater alignment with the Merit-Based Incentive Payment System requirements for Eligible Clinicians. We also are inviting comments on the burdens and hurdles that such policy changes might create for EPs and States."

MGMA comment

We strongly urge the agency to simplify the Promoting Interoperability program (formerly the Medicaid EHR Incentive Program) and harmonize the requirements with the Promoting Interoperability Program (formerly the Advancing Care Information) component of MIPS. Physician practices may have clinicians participating in the current Medicaid EHR Incentive Program while others are participating in MIPS. This creates significant technology and workflow challenges for the group and can negatively impact clinician productivity and drive up administrative costs.

At this point in the life of the incentive program, it is important to focus the intent of the program more on achieving effective and efficient interoperability and less on micromanaging clinician use of the technology. Requiring proof that providers are using these systems to perform routine functions is redundant. Mandating attestation of a security risk analysis, patient data access, e-prescribing, and health information exchange, for example, adds an unnecessary burden for clinicians participating in the program and is duplicative of existing incentives and legal requirements to use the EHR for these purposes. For instance, the Security Risk Analysis has been required by law since the HIPAA Security final rule was implemented in 2005 and the remaining objectives are fundamental functions of 2014 Edition and 2015 Edition CEHRT. Therefore, we urge the agency to adopt a policy of deeming Medicaid EPs to have met the Promoting Interoperability program (formerly the Medicaid EHR Incentive Program) score if they attest to implementing 2014 Edition CEHRT, 2015 Edition CEHRT or a combination of the two Editions. Removing the administrative requirements associated with meeting superfluous objectives would also be a further incentive for physician practices to adopt CEHRT.

Alternatively, CMS can reduce provider reporting burden by removing the requirement to capture numerators and denominators. For example, once e-prescribing systems, electronic

prescribing of controlled substances ordering, and PDMP query are enabled, there is no reason to require reporting numerators and denominators. E-prescribing is now the standard approach to issuing prescriptions and, once permitted by their state, providers are highly likely to take advantage of the efficiency and security afforded by e-prescribing systems to prescribe controlled substances in the same manner. Further, many states already require providers to consult their PDMP prior to prescribing controlled substances. This same logic applies to providing patients electronic access to their health information and the health information exchange objectives. There is value to each of these EHR functions and it is highly unlikely that providers will disable these systems.

We appreciate the opportunity to provide comments on the important set of issues related to Promoting Interoperability contained in the 2019 IPPS proposed rule. We look forward to continuing to work with you and others at HHS to advance constructive solutions to improve the healthcare delivery process. Should you have any questions, please contact Robert Tennant, Director, HIT Policy, at rtennant@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders M. Gilberg, MGA
Senior Vice President, Government Affairs