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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1677-P
7500 Security Boulevard
Baltimore, MD 21244-1850

On behalf of the members of the Electronic Health Record Association (EHRA), we are pleased to submit our comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule, *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 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices*.

Established in 2004, the EHRA is comprised of more than 30 companies that employ industry experts in the field of health information technology (IT) with a broad scope of experience, including physicians, nurses, pharmacists, technologists, and policy experts. These individuals represent the EHR software industry and reflect the breadth of the entire healthcare community. We support hospitals and ambulatory care providers in organizations of varied sizes and specialties that are using health IT to deliver high quality patient care. This response was developed through a collaborative process engaging representatives from our member companies. Our comments primarily address the proposed revisions to the EHR reporting period for the meaningful use (MU) program in 2018, the required usage of 2015 certified electronic health record technology (CEHRT) across programs, and CMS' request for information on flexibilities and efficiencies.

## Changes to the Medicare and Medicaid EHR Incentive Programs

### Proposed Revisions to the EHR Reporting Period

First, we appreciate CMS aligning the meaningful use reporting period for eligible providers (EPs) with the Merit-based Incentive Payment System Advancing Care Information (MIPS ACI) requirements for 2018. Also, we support CMS' proposal to utilize the MIPS Clinical Quality Measures (CQM) specifications for EP CQM requirements.

We acknowledge that providers have expressed their concerns about the timeframe needed to implement 2015 edition CEHRT; and, therefore, we encourage CMS to finalize any decisions around adjusting the timeframe sooner rather than later to avoid last minute confusion and complications.

As quality reporting continues to be separated from meaningful use/ACI measures, however, we urge CMS to provide clarity as to when the use of CEHRT is required for 2018 reporting. While the flexibility for MU is appreciated, requiring Medicaid EPs to report CQMs for a full year, though in alignment with current MIPS quality requirements, seems contradictory to CMS' goal of allowing additional time for providers to upgrade to 2015 CEHRT.

For example, if Provider X were struggling to implement 2015 CEHRT by January 1, 2018, a 90-day reporting period for Medicaid MU might offer relief by allowing him or her to select a 90-day period later in the year, perhaps September to November 2018. However, if quality reporting requirements for MIPS or for his or her particular state or alternative payment model require 2015 edition CEHRT to be adopted by January 1, 2018 anyway, then the 90-day flexibility does not actually aid Provider X. All of the deadlines need to be adjusted for the flexibility to be effective.

We suggest the ambiguity and potential timeline discrepancies be resolved by CMS, clarifying that for quality reporting (for MIPS or for Medicaid MU or for Inpatient Quality Reporting (IQR)) the expectation for CEHRT deadlines is that software meeting the (c)(1)-(c)(3) criteria and supporting the 2018 measure specifications is used for submission. CMS should clearly communicate this expectation to the states so it is shared by Medicaid programs.

Additionally, rather than requiring hospitals to report the first three quarters of data in 2018, we urge CMS to allow them to select any two consecutive quarters to report quality measures. Given CMS' proposed 90-day reporting period for MU, the ability for hospitals to choose the two quarters they want to report on would give them more flexibility to meet the 2015 CEHRT requirements without disrupting their IQR numbers. We support a similar approach for EPs under MU and ECs under MIPS for 2018.

We urge CMS to maintain consistency and be transparent regarding the usage of 2015 CEHRT across programs next year. We note that in addition to MU, MIPS ACI, MIPS quality, and IQR, there are several alternative payment models requiring the use of 2015 CEHRT in 2018. Many of these other programs do not have specific reporting requirements or measurement periods regarding the use of CEHRT and, therefore, do not have exact timelines for when 2015 edition CEHRT must be in place and used. We strongly urge CMS to provide clarification in this regard, as the current developer and provider assumption is that any provider participating in these programs will need to be using 2015 edition CEHRT on January 1, 2018. The same is true for the Medicaid MU program.

Another area where alignment and clarity is strongly needed is in the logic for the MU and MIPS ACI measures. For example, for MU measures, the measure specification states that the numerator is not constrained to the reporting period when the reporting period is less than a year (i.e., 90 days). For ACI measures, the specification states that the numerator is not constrained to the EHR reporting period *unless stated in the numerator statement*. Additionally, there are several measures that are calculated differently between Modified Stage 2 and Stage 3 as well as differently between MU and ACI. For example, for the Patient Access Measure, the specification states that for Modified Stage 2 and Stage 3 the patient may view, download, and transmit their information during the calendar year for MU; but for ACI, this action must occur during the performance period.

This inconsistency in the time period to complete the measure introduces unnecessary complexity for both providers and vendors who must maintain separate dashboards and reporting capabilities to support different calculations for the same measure. It is critical that CMS align these measures to remove small discrepancies and avoid significant waste.

## RFI on CMS Flexibilities and Efficiencies

We appreciate the opportunity to provide feedback on opportunities where CMS can alleviate unnecessary burden and improve efficiencies, while advancing its goal of promoting high quality care and reducing costs. The EHRA suggests that CMS focus on the areas below as it evaluates ways to reduce regulatory burden.

**Measurement and Reporting**
Overemphasizing the percentage of attainment on measures across regulatory programs, and on the certified software that supports those measures, inadvertently places the focus on measurement rather than on clinical goals and outcomes. Notable examples include secure messaging, patient education, and view, download, and transmit. This focus on measurement creates usability and workflow challenges and contributes to, in our view, much of the reported provider unhappiness with their EHRs. Fundamentally, quality program measures should prioritize improving health outcomes by providing better care and lowering costs versus reporting for the sake of reporting.

Furthermore, duplicative and sometimes conflicting reporting requirements across regulatory programs causes undue burden on providers and hospitals. For example, the electronic CQMs required for the CPC+ program are a subset of those required for the MIPS quality category. In 2018, when CPC+ will not count as an advanced APM for ECs at large organizations (defined as more than 50 ECs at the parent organization), providers should be able to submit quality measures one time to satisfy both CPC+ and MIPS, similar to what they are able to do when submitting quality measures via the web interface for the Shared Savings Program which determines their score for MIPS quality.[1] We encourage CMS to continue its efforts to streamline reporting requirements across programs.

**Complexity of Medicare Requirements**
In some instances, Medicare requirements around provider documentation have been overly complex, such as the supporting documentation needed for CPT codes, including evaluation and management codes. In other cases, however, requirements have lacked specificity, such as the level of documentation or "proof" needed to demonstrate the successful completion of improvement activities for the MIPS program. We urge CMS to be clear in specifying documentation expected of providers, while refraining from getting too granular with requirements.

In addition, our members and their customers have concerns with the role of audits, the need to provide protected health information (PHI) to auditors, and the burdens imposed by auditors, especially state Medicaid auditors who can require functionalities beyond what is required for certification. This adds considerable complexity and uncertainty for providers, counter to overall program goals.

Specifically, we urge CMS to put some restrictions or limitations on what can be requested in provider audits and, at minimum, provide additional guidance on what is recommended to be on file and its format (e.g., the data that must be included on reports that will be submitted with audits or that need

[1] https://qpp.cms.gov/docs/QPP_MSSP_and_QPP.pdf

not be included). It is challenging to support a customer who is getting audited for 2013 when each audit can ask for different data in different formats, especially when one considers state-level variation. Meaningful use objectives have changed up to four times since 2013, making it difficult to track which requirements were in place during a historical time period.

**Setting Attainable Timeframes**

The electronic access to and exchange of data continues to play a significant role in moving toward value-based care. As such access and exchange of data relies on standards, whether provided by standards development organizations (SDOs) or CMS itself, it is critical the data requirements are identified and communicated as early in the process as possible. Adequate time is needed to assess whether standards can support the requirements, update the standards as necessary, update systems to support the new/updated standards, test the access/exchange, and roll out the updated software to the relevant stakeholders. Each of these steps takes time and effort, so sufficient time is essential.

Unfortunately, we often experience late updates to requirements that create significant challenges from a timing perspective. Two current examples include the uncertainty around appropriate use criteria (AUC) for advanced imaging services and inclusion of patient relationship modifiers on claims where target implementation dates of January 2018 remain in effect, yet the specific data requirements are not yet known. Standards may not be able to support these requirements, thus providers and their health IT/EHR systems may not be able to implement the necessary updates, leaving providers not fully ready to provide the data on the target date.

In general, we urge CMS to set realistic expectations when setting an effective date. We suggest an 18 to 24 month time period between final rules, including all associated guidance, and when providers are expected to be using new functionality, so all necessary steps from standards development and updates, to testing, training, implementation, and other roll-out activities may be addressed in order to avoid unreasonable scrambling, increased risk of failure, churn, and wasted efforts. Lack of sufficient time causes major problems for both providers and developers, with the stresses on developers often causing indirect problems for providers.

**Coordinating Communication**

We appreciate past and current efforts to provide consistency across CMS teams and policies. Siloed CMS teams remain difficult to navigate when vendors and providers have questions and need clarification on requirements. CMS teams working on various programs need to use the same language and point to the same CEHRT requirements and timeframes as much as possible. Individual programs with unique certification requirements, such as CPC+, require special coordination with health IT developers to ensure that the expectations are practical on a given timeline. We encourage CMS to solicit vendor and provider involvement early and often when launching alternative payment models, as doing so will ensure they are not just attainable but successful.

Also, it is important to communicate earlier with providers regarding their MIPS QP status. In general, it appears that internal CMS communications silos lead to ACO/APM siloed communications.

Areas of recent communication challenges include: conflicting guidance from QPP help desk or MSSP help desk questions; or, when an FAQ is issued with guidance but is unclear to which programs it applies as many programs are similar. Particular attentiveness to aligning responses across help desks and specificity in FAQs as to scope is appreciated.

We appreciate this opportunity to provide feedback on this important rule, representing not only EHR developers but also the hospitals and ambulatory care organizations we serve. EHRA representatives would be happy to engage in further discussion. Please reach out to our Program Manager, Sarah Willis-Garcia at swillis@himss.org.

Sincerely,

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**About the EHR Association**

Established in 2004, the Electronic Health Record (EHR) Association is comprised of over 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit www.himssehra.org.