33 W Monroe, Suite 1700
Chicago, IL 60603
swillis@ehra.org
Phone: 312-915-9518
Twitter: @EHRAssociation

September 27, 2019

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

Dear Administrator Verma,

On behalf of the 33 member companies of the Electronic Health Record Association (EHRA), we are pleased to offer our comments on the Center for Medicare and Medicaid Services' (CMS) proposed rule on *CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies*, etc., which was published in the *Federal Register* on August 14, 2019.

The EHR Association's member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs across the United States. Our core objectives focus on collaborative efforts to accelerate health information and technology adoption, advance information exchange between interoperable systems, and improve the quality and efficiency of care through the use of these important technologies.

The MIPS Value Pathways (MVPs) represents a significant change in the MIPS program. The lack of clear definition on how MVPs will be implemented introduces risk for health IT companies in interpreting the technical requirements as well as committing adequate time to complete the needed development work in the proposed timeline. Because many details surrounding the MVP proposal remain unclear, we recommend that CMS formalize the proposed implementation of MVPs in future rulemaking to allow stakeholders to share comprehensive feedback on specific proposals.

At a minimum, CMS should revise the implementation of MVPs, allow providers to transition voluntarily, and then only assign MVPs after voluntary participation has been evaluated as successful.

A "glidepath" to MVP participation--such as allowing for multiple years of transition during which providers could elect to either participate in an MVP or use the current methodology, and subsequently choose between a set of MVPs--would moderate the burden associated with this change.

Our detailed responses related to these issues and others are included with this letter. Thank you for this opportunity to share the perspective of our members. We look forward to continuing to work with CMS and other stakeholders to advance widespread secure data exchange and to reduce clinician burden.

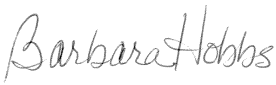
Sincerely,

Cherie Holmes-Henry
Chair, EHR Association
NextGen Healthcare

Hans J. Buitendijk
Vice Chair, EHR Association
Cerner Corporation

HIMSS EHR Association Executive Committee

David J. Bucciferro
Foothold Technology



Barbara Hobbs
MEDITECH, Inc.

Rick Reeves, RPh
CPSI

Emily Richmond, MPH
Practice Fusion Inc., a subsidiary of Allscripts

Sasha TerMaat
Epic

Courtney E. Tesvich, RN
Nextech

About the HIMSS EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of more than 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.ehra.org.

Section II F: Telehealth Services

Similar to our addition of the required face-to-face visit component of TCM services to the Medicare Telehealth list in the CY 2014 PFS final rule with comment period (78 FR 74403), since HCPCS codes GYYY1, GYYY2, and GYYY3 include face-to-face psychotherapy services, we believe that the face-to-face portions of these services are sufficiently similar to services currently on the list of Medicare telehealth services for these services to be added under Category 1.

The EHR Association is supportive of the proposal to add the face-to-face portions of three G-Codes for coverage under telehealth for services related to Opioid Use Disorder. We agree that adding these HCPCS codes will complement existing policies related to flexibilities in treating substance use disorders under Medicare Telehealth.

CMS proposes to include language in § 410.67(b) in the definition of opioid use disorder treatment services to allow OTPs to use two-way interactive audio-video communication technology, as clinically appropriate, in furnishing substance use counseling and individual and group therapy services, respectively.

The EHR Association is supportive of this proposal, with the understanding that health IT developers and providers will meet the regulatory requirements for privacy and security.

Section II J: Review and Verification of Medical Record Documentation

CMS is proposing to provide broad flexibility to the physicians, PAs, and APRNs who furnish and bill for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team.

The EHR Association is supportive of this proposal, which could significantly reduce physician burden.

Section II P: Payment for Evaluation and Management (E/M) Services

The EHR Association is supportive of the E/M proposal to adopt the new coding, prefatory language, and interpretive guidance framework issued by the AMA/CPT to accomplish greater burden reduction and is more consistent with the current practice of medicine. EHRA has consistently supported efforts to reduce clinician burden related to reporting requirements. As we have noted in past comments, the timeline will be critical to the success of this project; we recommend a minimum timeline of 18 months from final rule to required implementation.

CMS proposes the elimination of the history and/or physical exam to select among code levels, beginning January 1, 2021. The EHR Association recommends easing into this change, with a grace period to allow for the transition from the current requirement to the proposed elimination of history and physical exam.

Also, beginning January 1, 2021, CMS is proposing a choice of total time or medical decision making (MDM) to decide the level of office/outpatient E/M visit for levels 2-5 (using the revised CPT interpretive guidelines for medical decision making). In our interpretation, this suggests that the CMS wants to retain the flexibility of the original policy to allow the current approach to remain in effect as of January 1, 2021; if so, EHRA members recommend that CMS adopt a later date, such as January 1, 2022, to truly end use of the current documentation requirements.

We support the intention behind this initiative and for burden reduction. We agree it is a valid concern that the existing approach suffers from "note bloat" and is overdue for changes. However, the ramifications of this proposal as to the time and effort required to enable the optionality proposed should not be underestimated. Given the uncertainty of other payer action to move similarly, the changes for clinical workflow necessary, and the need for software remediation to support the new approaches, we suggest the one year transitional period to allow both providers and health IT suppliers time to acclimate to the new framework. Creating a cliff moment could negatively impact providers as they adjust to the new framework for documentation and E/M code level selection requirements.

Section III D: Medicaid Promoting Interoperability (PI) Program Requirements for Eligible Professionals (EPs)

The EHR Association supports continued alignment in programs to reduce reporting burden, including aligning the eCQMs available for Medicaid EPs in 2020 with those available for MIPS ECs for the 2020 Performance Period.

Reporting Period

The EHR Association supports the proposal to designate 2020 eCQM reporting period as 274 continuous days (aligning to January 1 - September 30, 2020). Providers are not required to use specific dates but may use any continuous 274-day period in CY 2020, allowing for reporting up to the entire year.

We note that any reporting period less than a calendar year creates the potential for skewing data, as specifications are written with the intention of a full year of reporting. Since the PI program does not pay for performance, this concern should not impact attestation. However, EHR developers do anticipate an increase in effort spent on measure validation and outcome questions from clients running non-year long reporting periods.

In response to the request for feedback on whether CMS should have proposed to require a submission date of January 1 - September 30, and a deadline in 2020, by which all eCQM reporting periods should

end, the EHR Association is supportive of a reporting period of 274 continuous days, rather than specifically mandating January 1 - September 30.

Section III E: Medicare Shared Savings Program Quality Measures

In response to CMS request for comment on aligning the Shared Savings Program quality score with the MIPS quality score, the EHR Association feels that more detailed information on the MVPs will be necessary in order to provide substantial comment on this proposal.

Section III K: Updates to the Quality Payment Program

2020 MIPS Performance Period Updates

Regarding the proposal to add new episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide, we encourage all measures to be fully vetted by providers to ascertain their clinical relevancy, and by health IT developers as to their technical feasibility.

MIPS Value Pathways (MVP) Request for Information

The EHR Association supports convergence of specifications for the same quality measures across submission types (e.g. eCQM vs Registry Reporting). Also, we support creation of focused measure sets that ECs would report on to facilitate meaningful comparisons of performance in the MIPS programs.

The lack of clear definition around how the MIPS Value Pathways will be implemented will prevent health IT companies from completing the technical development work within the proposed timeline. Also, providers may need one to two years for transition and another year to adopt new requirements for MVP specialties. If this program is proposed to exist as a voluntary participation model in Year 1, it should exist as a "pick your pace" type of framework. For instance, if five MVPs are created for specific specialties, providers within those specialties should be able to participate either within an MVP or within the existing MIPS framework.

MIPS Value Pathways represent a significant change in the program. It is unclear whether providers could operationalize such a change without a transition period that allows incremental adoption over time.

Further, CMS contemplates assigning providers MVPs. Many provider organizations pursue certain measures and activities around which they have designed practice and process improvements. In the event that their assigned MVP in 2021 does not align with those measures or activities, it may inadvertently lead to increased burden through change management costs and a reduction in certain providers' scores during the transition. Moreover, the MVP framework is still in its conceptual phase of design. No specific MVPs have been proposed.

Given these considerations, EHR Association members recommend that CMS revise the implementation of MVPs, allow providers to transition voluntarily, and then only assign MVPs after voluntary participation has been evaluated as successful. CMS should create a "glidepath" to MVP participation. For example, it could allow for multiple years of transition where providers could elect to participate in an MVP or use the current methodology, and subsequently choose between a set of MVPs.

Clinician Data Feedback

Timely feedback from CMS—within a 60-day period—for the claims and cost category would be useful for providers and practices participating in the program. It will be important to obtain feedback from providers and patients on what data they would find value in receiving and at what frequency. Our experience has been that healthcare providers find it beneficial to have more frequent feedback on performance in order to increase the opportunity for improvement during the program measurement period.

Enhancing Information for Patients

While this section will benefit from input directly from providers, the EHR Association feels that the multispecialty complexity would add a level of burden in the instances in which the multispecialty group requires submission requirements beyond the EHR's capabilities.

Implementing MVPs

CMS has proposed that, eventually, all MIPS ECs would not select quality measures or improvement activities from a single inventory; instead, the measures in an MVP would be connected around a clinician specialty or condition.

As currently proposed, the EHR Association has concerns that mandating specific measures by specialty could increase provider burden and complexity, specifically for multi-specialty groups. Larger groups consisting of providers crossing specialties would need more flexibility in choice of measures than smaller single specialty groups.

The proposal from CMS cites the agency's "intent that a population health measure/administrative claims-based measures would be layered into measuring the quality performance category, applied whenever there is a sufficient case minimum."

The EHR Association supports the addition of clinically appropriate, technically feasible measures. ECs are also interested in receiving feedback reports from CMS throughout the reporting year rather than only annually. This will allow clinicians to review and make improvements where appropriate.

CMS is requesting ideas for how PI measures can be better integrated into MVPs.

While it could be positive to eventually align the PI measures with specialty specific needs in MVPs, in general we agree that maintaining consistent PI objectives and measures across MVPs during the initial implementation will reduce provider confusion and burden on health IT developers.

CMS seeks feedback on how many improvement activities should be included in an MVP and how much flexibility there should be in selecting improvement activities.

The EHR Association supports providing groups the flexibility to choose from a specialty-specific set of activities. Input from the provider community and specialty groups on which improvement activities are most appropriate for inclusion in each MVP will be key.

CMS seeks feedback on the extent to which improvement activities in MVPs should be specialty specific, condition-focused improvement activities, versus other areas relevant to the practice such as patient experience and engagement, team-based care, and care coordination.

The EHR Association supports providing groups the flexibility to choose from a specialty specific set of activities, depending on specialty. Input from the provider community and specialty groups on which activities are most appropriate for inclusion in each MVP will be key.

Potential Issues

CMS seeks comment on the scope, definition, technical and clinical requirements for MVPs.

Health IT developers and specialty provider groups should be involved in refining the definition and requirements for MVPs. Specifically, we recommend the following:

1. Define a clear process by which clinicians would be assigned an MVP.
2. MVP assignments must be provided in a machine-consumable format so that health IT can provide monitoring and reporting tools to clinicians.
3. Clinicians need to know their MVP assignment well in advance of the measurement period so they know how they will be assessed, and where to focus improvement.
4. Clinicians need to have a way to ask for a targeted review of their MVP assignment if they think it is inappropriate for their practice.
5. Consideration needs to be given to how large, multi-specialty groups would be assigned and report on an MVP.
6. Quality measures must have mature specifications and be deemed clinically relevant by specialty groups before inclusion in an MVP.
7. Quality measure submission methods should align within a given MVP (i.e. all eCQMs or all registry measures). CMS could accomplish this by creating Registry and eCQM versions of each MVP.
8. Extend the implementation timeframe. With so many open questions and necessary changes, EHR developers and providers will need more than one year to develop and deploy updates to software, and organizations will need time to educate their clinicians as well. It is

important that CMS consider the amount of development work and IT department support efforts that creating reporting tools for numerous MVPs will take. Timelines should further be extended because development resources will already be constrained by the numerous requirements imposed as part of the 21st Century Cures Act NPRM.

CMS asks, should clinicians and groups be able to self-select an MVP or if an MVP should be assigned and the best way to assign if that is the case?

The EHR Association strongly supports flexibility and the ability to self-select. Engagement of both health IT providers and specialty provider groups in all aspects of this question will be key.

CMS seeks feedback on the timeframe for transitioning into MVPs.

After sufficient guidance is provided and time is allowed for health IT updates, EHR Association members support policies that provide a transition period, such as a pick-your-pace approach.

CMS is seeking feedback on how it can best engage stakeholders in the development of MVPs.

The EHR Association recommends continued active engagement, such as roundtable discussions with specialty groups and EHR developers, in order to elicit stakeholder feedback. When details surrounding its MVP proposal are able to be more fully defined, CMS should formalize proposed implementation of MVPs as part of a new rulemaking cycle.

Feedback for measure selection

CMS asks how MVPs can build on PI.

The EHR Association encourages input from providers and specialty groups, with EHR developer input on technical feasibility of recommendations.

CMS has requested input on how MVPs can reduce barriers to clinician movement into APMs.

The EHR Association encourages input from providers and specialty groups, with EHR developer input on technical feasibility of recommendations.

CMS has requested input on whether, in order to have comparable quality data, clinicians and groups should be required to use a certain collection type (e.g. eCQM/MIPS CQMs/Web Interface/QCDR).

EHR Association members agree requiring a clinician to use a particular collection type may increase provider burden and cost, as providers may need to contract and work with more vendors than they do today. An option for ensuring comparable data is to use the performance decile to compare performance, as providers falling within the same decile across collection type are considered

comparable. However, selecting a single submission mechanism could have significant consequences for health IT developers, clinicians, and third party intermediaries.

For example, if MIPS CQMs – or quality measures reportable through a registry – were required, it would force some providers who report using eCQMs today to contract with a registry vendor, incurring additional health IT costs.

CMS seeks comment on whether IAs in MVPs should be restricted to activities directly related to the clinical outcomes of the quality and cost measures in the MVP.

EHR Association members note that providers prefer more flexibility and choice, and would like to be able to be credited for other measures, outside of an MVP. Input from provider and specialty groups will be key.

Feedback for MVP Assignment

CMS asks, "How should we identify which MVP(s) are most appropriate for a clinician? Would it be based on the clinician specialty as identified in PECOS or the specialty reported on claims? If we assign an MVP, how would we be able to verify the applicability of the assigned MVP?"

Due to the different patient types within their practice, providers would prefer self-selected MVPs, as one MVP may not represent all of the types of patients they see and therefore would not be comparable to another practice.

CMS seeks input on whether clinicians and groups should be provided more than one applicable MVP, allowing clinicians to select their MVP(s) from those identified. "What tools would be helpful for clinicians to understand what MVP(s) might be applicable, for example NPI lookup, measure shopping cart, etc.?"

The EHR Association recommends providing a blend of different tools that support health system that select the profile that represents their type of practice.

Feedback on Transition to MVPs

CMS asks, "What practice level operational considerations do we need to account for in the timeline for implementing MVPs?"

The EHR Association recommends flexibility. Input from the clinical perspective of providers and health systems will be key. Increased complexity on where to gather data, for example from different data providers, will require more effort from providers.

Requesting feedback for Small and Rural Practices Participation in MVPs

The EHR Association notes that MVPs tend to increase the potential for health systems to work with different vendors to obtain different data types to meet the capture and reporting requirements. We recommend maintaining current flexibility for small practices. Input from these providers will be important.

Request for Feedback on Multispecialty Practices Participation in MVPs

The EHR Association requests additional clarity as we have technical feasibility concerns. While subgroups would help to get down to a more comparable grouping of physicians, this adds complexity to the program. EHR developers would need significant lead time to update systems to support a lower level of reporting.

Regarding criteria to identify which MVPs apply to multispecialty groups, we recommend consideration of the level of providers in the group, such as physicians and PAs.

Regarding questions on whether there should be a limit on the number of MVPs that could be reported by a multispecialty group, and mechanisms to assess a group's specialty composition to determine which MVPs apply, we recommend that CMS closely consider input from providers and specialty provider groups.

Although CMS seeks public comment on whether to align Shared Savings Program quality reporting requirements and quality scoring methodology with MIPS, the EHR Association feels that more detailed information on the MVPs will be necessary for substantial comment on this proposal.

Incorporating QCDR Measures into MVPs

The EHR Association feels further review is needed in relationship to clinicians being forced into specific submission methods based on their designated pathway. We urge CMS to encourage QCDRs to make their measures available to all providers, not just for those that have contracted with the QCDR.

Scoring MVP Performance

For providers who remain on the MIPS track (those providers who may not have a relevant MVP available yet), EHRA members recommend that current MIPS scoring standards be maintained (three-point floor, bonus points, etc.) If MVPs are finalized with no option to select measures within them, bonus points for high priority and outcome measures should be removed. If multiple collection types are allowed, the end-to-end bonus would still be applicable. If there is a level of choice around quality measures within an MVP, the outcome and high priority bonuses could still offer an incentive for providers to choose those measures.

MVP Population Health Quality Measure Set

The EHR Association advises that using administrative claims-based quality measures to replace some of the reporting requirements in the quality performance category will depend on the specific measures chosen for inclusion and how those measures will compare with the flexibility to be offered. Our members are interested in providing more specific comments once details are provided.

Group Reporting

The EHR Association advises that aggregating MIPS performance data across a group would require a development effort; thus, we request that lead time of at least 18 months for development and provider implementation and adoption be incorporated into the timeline.

Another revision proposed by CMS would require solo practitioners and groups of 10 or fewer ECs electing to participate in MIPS as a virtual group to aggregate their performance data across the virtual group's TIN, and for PI must also aggregate performance data of all MIPS ECs in the virtual group's TIN for which the virtual group has data in CEHRT. If this proposed revision is only to insert the past instruction into regulatory text—with no real change in requirements beyond what has already been in place—the EHR Association does not anticipate additional work associated with this proposal.

MIPS Performance Category Measures and Activities - Quality Performance Category

The EHR Association has concerns about increasing data completeness to 70% for the 2022 payment year. We recommend maintaining the current data completeness level as raising the level may result in an increased burden for providers practicing within multiple EHRs during the reporting period, such as clinician organizations migrating between systems.

CMS seeks comment "as to whether we should consider realigning the MIPS quality measure update cycle with that of the eCQM annual update process."

The EHR Association is supportive of aligning these update cycles, provided that updates happen on the earlier cycle. The earliest update possible is most helpful for ensuring that developers are able to complete development with appropriate time for provider implementation.

CMS is proposing "changes to the MIPS quality measure set as described in Appendix 1 of this proposed rule, including: substantive changes to existing measures, addition of new measures, removal of existing measures, and updates to specialty sets."

The EHR Association is generally supportive of this proposal. However, we have concerns regarding removing duplicate measures when the retained measure is only available in one collection type. For example, two immunization eCQMs are proposed to be removed as duplicative measures. However, they are replaced by an immunization measure that is only available as a MIPS CQM. CMS should be mindful of collection types when proposing to remove measures due to duplicative offerings across

collection types. ECs are not typically contracted with multiple submission vendors, EHR, Qualified Registry, and QCDR for example, which will make a registry only measure unavailable to many ECs.

CMS seeks comment "on whether we should increase the data completeness threshold for extremely topped out quality measures that are retained in the program due to limited availability of measures for a specific specialty and potential alternative solutions in addressing extremely topped out measures."

The EHR Association has concerns regarding developer and provider burden that may be incurred by supporting different data completeness thresholds for different measures. Additionally, increasing data completeness may cause burden for providers practicing within multiple EHRs during the reporting period, such as clinician organizations migrating between systems.

CMS is requesting information on a potential opioid overuse measure.

Members of the EHR Association provided information to measure developers during health IT developer calls. In order to provide additional, more specific feedback, members would need access to updated measure specifications.

CMS proposes to add regulatory language to clarify that if quality data re submitted selectively such that the data are unrepresentative of MIPS EC or Group performance, any such d ata would not be true, accurate, or complete.

The EHR Association supports this clarification.

Selection of MIPS Quality Measures

The EHR Association supports alignment between programs to reduce provider burden, such as the proposal to generally align the CY 2020 eCQM reporting requirements for EPs participating in Medicaid with the MIPS eCQM reporting requirements.

Cost Performance Category

The EHR Association supports CMS' proposal to weight the cost performance category at 20% for MIPS payment year 2022, 25% for MIPS payment year 2023, and 30% for MIPS payment year 2024 and all subsequent MIPS payment years.

Likewise, we feel that CMS' recommendation to change its approach to proposing attribution methodologies for cost measures by including the methodology in the measure specifications would be a positive change.

We request additional clarification on CMS' proposal to add 10 episode-based measures; to modify the total per capita cost and Medicare Spending Per Beneficiary (MSPB) measures; and the future inclusion of an additional episode-based measure.

Because providers have indicated that they need more feedback on their cost performance from CMS, we recommend that CMS provide regular feedback in a timeframe that allows providers to make targeted improvements.

CMS Study on Factors Associated with Reporting Quality Measures

Members of the EHR Association encourage CMS to continue to seek ways to incentivize clinician organizations and health IT developers to participate in measure or program development to ensure true quality measurement and improvement.

Promoting Interoperability Performance Measures-eRx Measures

The EHR Association is supportive of the proposal to make the Query PDMP measure optional and eligible for five bonus points in CY 2020, and the corollary proposal to make ePrescribe measure worth up to 10 points in CY 2020. Also, we are supportive of the proposal to change the measure to a yes/no, attestation-only measure in both CY 2019 and CY 2020.

While members support the proposal that both the Query PDMP and Verify Opioid Treatment Agreement (VOTA) measures would be eligible for five bonus points. We disagree with the proposal to remove the VOTA Measure in 2020, but support including it as an optional measure until there is clarity and additional guidance on how the VOTA is expected to be measured.

CMS seeks stakeholder feedback on useful ways to measure the efficiency of healthcare processes due to the use of health IT, and what are measurable outcomes demonstrating greater efficiency in costs or resource use that can be linked to the use of health IT-enabled processes.

CMS has solicited comments on whether it should include a metric to measure provider efficiency within their EHR under the Promoting Interoperability category. EHR Association members believe that this will add to provider and health IT developer burden while providing marginal benefits to efficiency. It would require an EHR developer to capture and track whatever metrics are proposed, which would in turn increase the provider's reporting and compliance burden.

There are ample market incentives to promote EHR efficiency. Efficiency is a major product differentiator for EHR developers, and providers have an incentive to efficiently use technology to lower their operating costs.

What are key administrative processes that can benefit from more efficient electronic workflows; for instance, conducting prior authorization requests? How can we measure and reward providers for their uptake of more efficient electronic workflows?

EHR developers have heard from our provider customers that, in general, they find that ePA contributes to administrative burden due to the lack of standards across payers.

RFI on Provider to Patient Exchange Objective

Seeking comment if there are specific data elements that may be more or less feasible to share no later than one business day through open API and if/when such an implementation if feasible.

We understand that CMS has stated that Promoting Interoperability requirements do not contravene provider discretion, HIPAA or existing state laws governing health information privacy or availability of health information for patient access. However, we recommend that CMS explicitly address this concern to clarify that state laws of this kind preempt the timing requirements of diagnostic test results. In so doing, state laws would need to set a mandate as to when and how certain diagnostic test results can be shared with patients.

In the ONC 21st Century Cures Act proposed rule (84 FR 7481 through 7484), there is a proposal regarding requirements around persistent access to APIs, which would accommodate a patient's routine access to their health information without needing to reauthorize their application and re-authenticate themselves. CMS seeks comment on whether the Promoting Interoperability performance category measure should be updated to accommodate this proposed technical requirement for persistent access.

The EHR Association suggests that no measure is needed when the updated Certification Edition identifies a minimum expiration period before one may require consumers to re-authenticate. We are concerned with potentially conflicting requirements and suggest that CMS work with the ONC so that any requirements in this space are done through certification criteria rather than measures.

Also, EHR Association members are concerned regarding the statement, "without needing to reauthorize their application and re-authenticate themselves." It is poor security practice to never have an expiration date by when an application is to be reauthorized and a user is re-authenticated. We strongly suggest expiration periods be permissible, but that this period be not less than three months.

If ONC's proposed FHIR-based API certification criteria is finalized would stakeholders support a possible bonus under PI for those who early adopt a standards-based API?

The EHR Association supports this proposal in general, with the consideration that CMS should not initially require any specific FHIR standard or implementation guide in order to receive these bonus points, that it allows for the use of any FHIR standard to satisfy this bonus opportunity during any rollout period specified by the ONC for adoption of any newly certified API related capabilities, and that the

rollout period not begin prior to the first calendar year after testing tools are available. The rationale for this timing is the transition period where various FHIR standards may continue to be used until providers have fully migrated to EHR conformant to new certification requirements.

Do stakeholders believe that incorporating this alternative measure into the Provider to Patient Exchange objective will be effective in encouraging the availability of all data stored in health IT systems?

The EHR Association proposes that, if a criterion supporting standards-based API access to the USCDI and for patient export of EHI is adopted into the proposed updated ONC 2015 Certification Edition, then an alternative measure focused on API and export will not have much benefit beyond one that focuses on providers having turned on such capabilities, as providers will have limited control over whether patients actually use the capabilities, as already demonstrated with View Download and Transmit. The EHR Association proposes not introducing an alternative measure.

In relation to the Provider to Patient Exchange objective, as a whole, how should a required measure focused on using the proposed total EHI export function in CEHRT be scored?

Because the use of the functionality would be driven by patient interest, the EHR Association suggests that the measurement of provider action be "yes/no" based on their enabling of the feature included in the updated ONC 2015 Edition.

If this certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure? Should this measure be established as an attestation measure?

The EHR Association questions the value of making this is a bonus measure, while we do agree that this can be established as an attestation measure would be most applicable if this were adopted. A bonus measure should be attainable for all providers and it is not clear that everybody will utilize this capability, although it would be available through certified software if the export criterion is included in the next certification edition.

In the long term, how do stakeholders believe such an alternative measure would impact burden?

If the measure is an attestation to having the capability available, the EHR Association is not concerned about additional burden. If the measure goes beyond that, the concern is that additional burden is imposed while the provider has limited control on the patient's behavior to actually use the capabilities. For example, while the capability has the opportunity to reduce burden as the patient can access their information directly without provider intervention, the patient/consumer is the party that will drive adoption based on actual value received from having such access.

If stakeholders do not believe this will have a positive impact on burden, in what other way(s) might an alternative measure be implemented that may result in burden reduction? Please, be specific.

As indicated on the prior question, other than a measure to address availability, the focus should be on patient awareness and education to drive adoption and use.

Which data elements do stakeholders believe are of greatest clinical value or would be of most use to health care providers to share in a standardized electronic format if the complete record was not immediately available?

The EHR Association encourages the use of the USCDI standard when identifying the most appropriate data to be used in information exchange, rather than the vague concept described under the current EHI Export criteria within the ONC's NPRM, for which no agreed-to standards have been established. Use of a USCDI-based approach will enable focus on appropriate expansion of the required data set predicated on standards as the data set is expanded in future USCDI versions, while avoiding burden to develop, support, and deploy non-standard capabilities. Also, the EHR Association suggests that this question be addressed in the context of and as part of the ongoing development of the USCDI.

Do stakeholders believe that we should consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long-term care, behavioral health, and home and community based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should we consider when implementing a health information exchange across the care continuum health IT activity in the Promoting Interoperability performance category?

Increased participation in the trusted exchange frameworks as further promoted through the ONC's Trusted Exchange Framework and Common Agreement (TEFCA) could be a way in which to drive the care across the continuum for this specific request. The EHR Association suggests that participation in existing trusted exchange frameworks, particularly those at a national level, while perhaps not fully aligned with all the proposed elements of TEFCA, would already constitute substantial progress and should be encouraged immediately as it already can increase data access and exchange, while reducing information blocking concerns and not waiting for TEFCA to be fully rolled out.

While we support interoperable exchange of health information across the care continuum, it is not clear how including a new health IT activity measuring exchange between organizations and their community partners such as post-acute, long term, and behavioral health facilities will further promote exchange with those entities. Instead, we recommend that CMS examine existing regulatory and technical barriers that may exist to exchanging health information with those stakeholders, and consider how it might address them.

What criteria should we employ, such as specific goals or areas of focus, to identify high priority health IT activities for the future of the performance category?

When considering health IT activities, the EHR Association recommends focusing on activities centered on the data categories in the USDCI as it expands over time. Such activities might measure the data's availability or actions that further enable patient access to their data.

Are there additional health IT activities we should consider recognizing in lieu of reporting on existing measures and objectives that would most effectively advance priorities for nationwide interoperability and spur innovation?

In general, the EHR Association notes that attestation measures are a method to introduce concepts to the program with minimal reporting burden on providers. In that light, the EHR Association suggests the following topics for consideration:

- e-Prescribing of controlled substances in areas with lower adoption rates.
- Patient event notifications.
- Encourage all stakeholders to participate in trusted exchange frameworks to (a) increase adoption of interoperable tools across all stakeholders, and (b) have the full continuum of data on the patient accessible, regardless of setting, facility, or specialty.

Do stakeholders believe that CMS and ONC patient matching efforts impact burden?

In the absence of a singular unique patient identifier—and even if there was one—patient registration and matching processes require ongoing effort at the front-desk and back-office to identify and resolve duplicate records, or records linked to the wrong patient. Introduction of additional data beyond what is already collected during the registration process to improve the ability to enable systems to get higher quality and volume of matches requires enhancements to those processes to ensure those fields have high data quality value. This would add to the documentation burden.

The EHR Association suggests that patient matching efforts can have positive impacts on burden where the focus is on identifying a minimum data set that includes a small set of strong, unique identifiers (e.g., driver's license, Medicare Beneficiary Identifier); adoption of data format standards for select additional data already used during the registration processes and part of USCDI (e.g., address, date of birth, mobile telephone number); and improved training and data collection systems, which will increase data quality from the start. This can reduce burden in the registration processes, as well as improve the ability to access the complete patient record.

If stakeholders believe that patient matching is leading to increased burden, what suggestions might stakeholders have to promote interoperability securely and accurately, without the requirement of a UPI, that may result in burden reduction?

Because patient matching is consistently brought into discussions, the EHR Association believes it should be set as a priority for advancing. We recommend expansion of demographic matching by adopting a minimum data set for patient matching along with a vocabulary. In the longer term, this could potentially expand to the use of patient email/cell phone number or other similar identifiers.

Patient matching efforts can lessen burden by identifying a minimum data set that includes a small set of strong, unique identifiers (e.g., driver's license, Medicare Beneficiary Identifier), adoption of data format standards for select additional data already used during the registration processes and part of USCDI (e.g., address, date of birth, mobile telephone number); and improved training and data collection systems, increasing data quality from the start. This can reduce burden in the registration processes, as well as improve the ability to access the complete patient record.

RFI on Integration of Patient-Generated Health Data into EHRs Using CEHRT

What specific use cases for capture of PGHD as part of treatment and care coordination across clinical conditions and care settings are most promising for improving patient outcomes? For instance, use of PGHD for capturing advanced directives and pre/post operative instructions in surgery units.

EHR Association members agree that the use cases provided are broadly applicable to many providers. It is important to consider unsolicited health data that physicians must review, and the potential to increase physician burden when considering other requirements. We suggest focusing on specific, high priority use cases for targeted improvement. For example, home glucose or home BP could be valuable to many providers.

Any PGHD program or measurement should allow for flexibility for clinicians to determine what is best for the care of their patients.

Should the Promoting Interoperability performance category explore ways to reward providers for engaging in activities that pilot promising technical solutions or approaches for capturing PGHD and incorporating it into CEHRT using standards-based approaches?

The timeliness of what might be required and the implementation of any development requirements could be troublesome for pilots if they create additional needs beyond what is already available in the EHR.

EHR Association members recommend use cases that are EHR-agnostic and easily adoptable by groups of providers using functionality already available today. Currently, patient-entered data may not adhere to standards; therefore, we suggest CMS work with the ONC on determining the types of patient-generated data that needs to be prioritized, which could lead to improved technical solutions. Focusing

on standardized approaches for specific data classes and elements would reduce custom development and improve the likelihood of success. Broader ranges of activities could be considered beyond the current provisions if a standardized approach is adopted.

Should healthcare providers be expected to collect information from their patients outside of scheduled appointments or procedures? What are the benefits and concerns about doing so?

The EHR Association suggests CMS clarify which of the two disparate use cases it is referring to:

1. Collection of patient generated data on a continuous basis, or
2. Targeted collection of data/updated data before appointments or other encounters etc.

By appropriately focusing the scope of data collection, the added value for clinicians would be high. We discourage use cases that have not been vetted by providers to determine what data is valuable. We note that the question asked could relate to benefits and concerns for providers as well as patients. Also, patients are sensitive to duplication of their efforts when they utilize technology and then encounter the same requests to duplicate their responses. With that said, does the question refer to providers or patients when asking about benefits?

RFI on Engaging in Activities that Promote the Safety of the EHR

Considering offering points towards the PI category for those ECs who conduct an assessment based on the High Priority Practices.

Overall, the EHR Association supports this recommendation; however, we note that there are challenges in measuring performance beyond attestation. Any measurements based on the ONC SAFER Guides should be optional or eligible for bonus credit for the foreseeable future. Some of the SAFER guidelines lend themselves to some degree of measurement, (e.g. CPOE, use of evidence-based order set, compliance structured data entry for allergies, medications and pharmacy orders, and override rates) and results reporting (e.g., structured data usage and safety monitoring recommendations). However, many of the SAFER guidelines are less amenable to measurement or may be under the safeguard of quality assurance/patient safety work-product protections.

Given the significance of recent changes to the PI program over the past two rule-making cycles, introducing a completely new set of measurements and attestations, which may be ambiguous or technically infeasible, would introduce additional uncertainty and burden to all stakeholders. In order to minimize burden on healthcare providers and organizations, implementation of this change would require multi-stakeholder involvement with proposals released for comment to ensure the data required for reporting is technically feasible without extraordinary effort on behalf of providers and represents value to the reporting parties to affect meaningful change.

Also inviting alternatives to the SAFER Guides, including appropriate assessments related to patient safety.

Requiring implementation of SAFER Guidelines has the potential to introduce additional burden in the ambulatory space compared to the inpatient/hospital setting with more organizational resources. While there are a subset of the SAFER Guidelines that might be obviously beneficial to the providers, the risk is that many of them will be perceived as additional burden for providers without obvious benefit beyond meeting a reporting requirement for a modest bonus.

Potential alternatives to the SAFER Guidelines could include a subset of IHI Patient Safety Practices as goals which might provide more obvious benefit in the ambulatory setting (e.g. Referral Management, Results Management, Medication Management, Diagnostic Errors/Delays). Demonstrating the introduction of best practices enabled by EHR technology, accompanied with pre/post implementation metrics to support attestation of improvement. This could be considered similar to EHR-enabled Improvement Activities which provided for bonus points in the early stages of the MIPS program.

Allowing MIPS Eligible Clinicians Participating in MIPS APMs to Report on MIPS Quality Measures

The EHR Association would be interested in providing future comment, but will need more information on how the MIPS Value Pathways will affect choices in quality measurement that would in turn be reflected in the scoring.

Scoring the Quality Performance Category for the Following Collection Types: Medicare Part B Claims Measures, eCQMs, MIPS CQMs, QCDR Measures, CMS Web Interface Measures, the CAHPS for MIPS Survey Measure and Administrative Claims Measures

The EHR Association appreciates CMS' consistency in scoring.

Proposing to develop benchmarks based on flat percentages in specific cases where CMS determined the measure's otherwise applicable benchmark could potentially incentivize inappropriate treatment

The EHR Association has several concerns with this proposal to base benchmarks on flat percentages. Based on the proposal, only two collection types would be updated to the flat benchmarks—claims and MIPS CQMs. This seems to unfairly lower the bar for clinicians utilizing the registry and claims version of the measures without providing the same adjustment to all collection types. We typically see eCQMs generate lower benchmarks than like measures in other collection types but believe this can be attributed to the stricter requirements of discrete EHR documentation, rather than allowing for manual abstraction and review. With this in mind, it seems that all ECs could find themselves incentivized to increase their score by providing inappropriate treatment. We see this as a potential consequence of any measure across any pay-for-performance program, as participants directly benefit from increasing their measured performance.

If changes to the benchmarks are finalized, we would like to see a proportional method applied to all available collection types. The proposed method would substantially shift the decile ranges in some instances; for example, the lower range of decile 4 for the claims collection type for MIPS 236 would be reduced from 63.98 to 30. The MIPS CQM collection type for the same measure and decile would be reduced from 60.05 to 30. Meanwhile, because the eCQM collection type is not proposed to change, those providers would need to earn a 56.83% to get into the 4th decile. This results in eCQM performance by an EC needing to be nearly double that of their peer participating through another collection type to earn the same points, even though the eCQM specification has a lower performance benchmark. We urge CMS to consider another method such as reducing all benchmarks, for all collection types, by a certain percentage, an equivalent number of points, or not at all.

Incentives to Use CEHRT to Support Quality Performance Category Submissions

The EHR Association supports maintaining the cap on measure bonus points.

Facility-Based Measurement Eligibility

The EHR Association appreciates the clarification and supports this proposal.

Proposed Requirements for MIPS Performance Categories that Must be Supported by Third Party Intermediaries

The EHR Association believes that developers (Qualified Registries, QCDRs and Health IT suppliers) should be allowed to determine the most appropriate use of their resources and choose which MIPS categories to submit.

ECs and groups are informed prior to the performance period of the categories that each QR and QCDR support, which enables them to make an informed decision. If ECs and groups want to use a QR or QCDR that allows them to report Quality, IAs, and PIs all together, they can make that decision on their own. This proposal would increase QR and QCDR burden without any distinct benefit as ECs and groups wanting to use a single submission already have the opportunity to do so.

CMS is proposing that Qualified Registries provide timely feedback to their clients more than four times a year. This feedback should include how the clinicians compare to others who have submitted data.

The EHR Association agrees it is beneficial to ECs to receive more frequent feedback and registries should be encouraged to provide feedback as frequently as possible. However, we do have concerns that requiring comparison data with other client participants within that registry seems unnecessary and potentially confusing to the EC. Comparing an EC or group's performance to only those participating within the same registry could be confusing if an EC believes they are outperforming their peers when that might not be representative of the overall performance benchmark. It would be more appropriate

to compare an EC or group's performance to the published benchmark. This would give a more accurate potential measure score.

Ultimately, how an EC is performing compared to their peers within a single qualified registry vendor does not directly correlate with the score they will receive in the MIPS program. Each EC or group reporting through a single vendor may need to take differing action to improve quality, considering qualified registry vendors could be supporting clinicians with various specialties, clinical systems, and ancillary support systems.

CMS seeks comment for future notice-and-comment rulemaking on whether clinicians and groups can start submitting their data starting April 1 to ensure that the qualified registry is providing feedback and the clinician or group during the performance period.

The EHR Association requests clarification on whether CMS is considering requiring ECs and groups to contribute data to a qualified registry by April 1. If this is the case, we do not support this change.

Currently, qualified registries are required to identify and publish the latest date a registry could accept new clients. We would support enhancing this process to add a minimum date that an EC or group must begin contributing their data to their chosen health IT developer in order to be eligible for submission. This allows flexibility by allowing developers who choose so to support those ECs or groups who cannot get data submitted by April 1, while also allowing developers to designate their own minimum requirements based on their unique product and data collection requirements.

Public Reporting on Physician Compare

The EHR Association generally supports the concept of publishing this type of information as transparency, in an easily understood and digestible format, is fundamental to patients making informed decisions. We defer to the physician community on the best way to achieve this goal.

Promoting Interoperability

The EHR Association supports the CMS proposal to include an indicator on Physician Compare for the eligible clinicians and groups that submit a "no" response to any of the three prevention of information blocking attestation statements.

Align Other Payer Medical Home Model that aligns with CMS for a Multi-payer model

The EHR Association is generally in favor of aligning as many programs as possible.

Compromised Data Exception

As CMS has recognized, there are instances where an Eligible Clinician's (EC) data may be compromised for reasons outside of the EC's control. In these instances, EHR Association members believe that allowing the EC to reweight their MIPS score would encourage more robust compliance efforts from

health IT developers and third party intermediaries, and would encourage EC participation in MIPS by providing relief when ECs encounter technical issues that are outside their control.

In the event that CMS were to finalize such an exception, we note that health IT developers and third party intermediaries will still have a significant interest in maintaining accurate data. For example, in the context of CEHRT, compromised quality reporting data or Promoting Interoperability data would frequently amount to nonconformities under the ONC certification program. This exposes the health IT developer to a number of remedial actions through the surveillance framework.