



September 11, 2017

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
Submitted electronically <http://www.regulations.gov>

Re: CY 2018 Physician Fee Schedule Proposed Rule

Dear Administrator Verma:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the CY 2018 Physician Fee Schedule proposed rule.

AMIA is the professional home for more than 5,400 informatics professionals, representing frontline clinicians, researchers and public health experts who bring meaning to data, manage information and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations.

We are generally supportive of policies that promote and further the use of health IT and support research. Below, we provide our specific comments for the proposals in this rule related to the use of telehealth, appropriate use criteria (AUC), evaluation and management (E/M) coding, quality reporting, and the Medicare EHR Incentive Program. We urge the agency to consider our comments as constructive, and with the aim of helping CMS move toward a more desirable, holistic approach of improving care through robust use of health IT and other informatics tools.

Specifically, **AMIA supports the CMS proposal to initiate the AUC program in 2019, rather than in January 2018.** While we generally support the precepts of the program, and believe it can demonstrate an important use case of informatics in care delivery, the additional time will give ordering and furnishing clinicians time to implement clinical decision support mechanisms (CDSMs) and adjust workflows appropriately. We urge CMS to engage with ordering and furnishing clinicians closely over the intervening months to position a viable 2019 start date.

In addition, **AMIA strongly supports CMS proposals to review requirements for Evaluation and Management (E/M) documentation guidelines for history and physical exam.** In particular, AMIA recommends that CMS remove auditing requirements associated with the history and physical exam elements of both the 1995 and 1997 E/M documentation guidelines. Once

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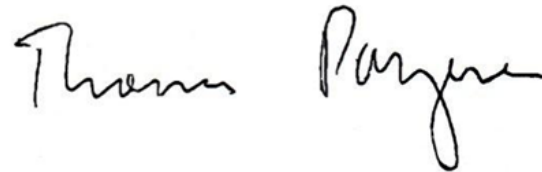
auditing requirements are removed, individual practitioners and organizations can better focus on documentation that is relevant to their clinical setting.

We hope our comments are helpful as you undertake this important work. Should you have questions about these comments or require additional information, please contact Jeffery Smith, Vice President of Public Policy at jsmith@amia.org or (301) 657-1291. We look forward to continued partnership and dialogue.

Sincerely,



Douglas B. Fridsma, MD, PhD, FACP,
FACMI
President and CEO
AMIA



Thomas H. Payne, MD, FACP, FACMI
AMIA Board Chair
Medical Director, IT Services, UW Medicine
University of Washington

Enclosed: AMIA Detailed Comments Regarding CY 2018 Physician Fee Schedule Proposed Rule

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Comment Solicitation on Medicare Telehealth Services

For CY 2018, CMS is seeking information regarding ways that it might further expand access to telehealth services within current statutory authority. CMS defines eligible originating sites and the distant site practitioners who may furnish and bill for telehealth services, with originating sites limited to those located in rural health professional shortage areas (HPSAs) or in a county that is not included in a metropolitan statistical area (MSA).

AMIA Recommendation: While we recognize that CMS is limited by statutory authority in its ability to change telehealth limitations related to geography, patient setting, or type of furnishing practitioner, we believe that there are ways to expand the use of telehealth within CMS’s authority. In recent comments to the FCC’s Connect2Health Task Force, AMIA wrote that “access to broadband is, or soon will become, a social determinant of health.”^{1, 2, 3} CMS can play a role in strengthening this social determinant by working with the FCC to assess broadband connectivity in rural HPSAs and areas outside of MSAs. Furthermore, CMS can continue to incentivize the use of telehealth through more telehealth-focused MIPS improvement activities (IA). There is currently one IA that focuses on telehealth, and the proposed QPP Year 2 rule does not seek to add any new ones that focus on telehealth as a delivery mechanism. Finally, CMS should extend telehealth coverage waivers to more APMs to encourage experimentation with telehealth services.

E/M Guidelines Public Comment Solicitation

In reviewing E/M documentation guidelines and stakeholder feedback, CMS generally agrees that there may be unnecessary burden with these guidelines and that they are potentially outdated. CMS believes this concern is especially true of the requirements for the history and the physical exam components of the E/M documentation guidelines. Thus, CMS is seeking comment on how it might focus on initial changes to the guidelines for the history and physical exam because

¹ Perzynski, et al. found that patient portals have shown potential for increasing health care quality and efficiency, and that lower rates of initiation of portal use was found for racial and ethnic minorities, persons of lower socioeconomic status, and those without neighborhood broadband internet access. They conclude that Internet access and other factors influencing patient portal use could worsen health disparities. (Perzynski A., Roach, M.J., Shick, S. et al; Patient portals and broadband internet inequality. J Am Med Inform Assoc 2017 ocx020. doi: 10.1093/jamia/ocx020)

² Graetz, et al. found similar results when conducting a cross-sectional survey of 1,041 patients with chronic conditions in a large integrated health care delivery system, indicating similar disadvantages for online access to health records and the ability to exchange secure messages among disadvantaged groups. (Graetz I, Gordon N, Fung V, et al. The Digital Divide and Patient Portals: Internet Access Explained Differences in Patient Portal Use for Secure Messaging by Age, Race, and Income. Med Care. 2016 Aug;54(8):772-9. doi: 10.1097/MLR.0000000000000560.)

³ Gibbons, et al. conducted a wide-ranging systematic evidence review of consumer health informatics, defined as any electronic tool, technology, or system that is (1) primarily designed to interact with health information users or consumers (anyone who seeks or uses healthcare information for nonprofessional work), (2) interacts directly with the consumer who provides personal health information to the CHI system and receives personalized health information from the tool application or system, and (3) is one in which the data, information, recommendations, or other benefits provided to the consumer, may be used in coordination with a healthcare professional but is not dependent on a healthcare professional. Gibbons, et al found that a system-level barrier related to Internet access at home or in the community was prevalent across all inclusive studies. (Gibbons, M.C., Wilson, R.F., Samal, L. et al. Consumer health informatics: results of a systematic evidence review and evidence based recommendations. Behav. Med. Pract. Policy Res. (2011) 1: 72. doi:10.1007/s13142-011-0016-4)

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documentation for these elements may be more significantly outdated, and that differences in the MDM component are likely the most important factors in distinctions between visits of different coding levels. CMS is also seeking comment on whether it would be appropriate to remove the documentation requirements for the history and physical exam for all E/M visits at all levels.

While CMS believes MDM guidelines may also need to be updated, it believes in the nearer term it may be possible to eliminate the current focus on details of history and physical exam, and allow MDM and/or time to serve as the key determinant of E/M visit level. CMS is thus seeking public comment on this approach. CMS is also seeking comment on how such reforms may differentially affect physicians and practitioners of different specialties, including primary care clinicians, and how we could or should account for such effects as we examine this issue. CMS is additionally seeking comment on whether CMS should leave it largely to the discretion of individual practitioners to what degree they should perform and document the history and physical exam.

AMIA Recommendation: AMIA strongly supports the reduction of burden via removal or substantial reduction of documentation requirements for the history and physical exam for all E/M visits at all levels. We concur that individual practitioners and organizations should determine the degree of detail captured for these activities, based on the needs of clinically-motivated documentation and communication, rather than CMS. Because this proposal relates solely to current medical practice and not to the established values of E/M services, we further agree with CMS that any revisions made to the E/M documentation guidelines should not result in a reevaluation of the entire E/M code set. Rather, AMIA supports the removal of auditing requirements associated with the history and physical exam elements of both the 1995 and 1997 E/M documentation guidelines. Once auditing requirements are removed, individual practitioners and organizations can better focus on documentation that is relevant to their clinical setting. In the longer term, we believe that CMS should work with the AMA and other interested parties on potential revisions of the CPT E/M codes. Simply revising documentation guidelines while retaining code definitions based on unclearly or inconsistently understood definitions may add to clinicians' uncertainty and could lead to inaccurate coding.

We additionally agree with CMS that shared health information via EHR has changed the character of extended patient histories since the E/M documentation guidelines were established. Insofar as CMS reviews overall documentation burden reductions, we note that some of the information that is relevant to the diagnosis and treatment of patients may, in some instances, be most effectively entered by other members of the care team, captured automatically by devices or other information systems, or captured and entered by patients themselves.⁴ Patient-entered data could supplement

⁴ Payne T.H., Corely S., Cullen T.A. et al. Report of the AMIA EHR-2020 Task Force on the status and future direction of EHRs. *Journal of the American Medical Informatics Association*, Volume 22, Issue 5, 1 September 2015, Pages 1102–1110, <https://doi.org/10.1093/jamia/ocv066>

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high value data, such as Past Medical, Family and Social History (PFSH), that patients can often enter as well or better than providers.⁵

AMIA thus agrees with CMS that updated E/M guidelines, coupled with technological advancements in voice recognition, natural language processing, and user-centered design of EHR could improve documentation for patient care while also meeting requirements for billing and population health management. To this end, CMS should encourage and support the study of alternative approaches and media that could help providers use their time more efficiently, such as by sound recording patients' history, the physical, and the patient advice portion of the visit, instead of writing it all down.⁶ This will both reduce clinician documentation burden and give providers flexibility in utilizing health IT effectively for their specific practice setting.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

CMS is proposing that ordering professionals must consult specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. This proposed effective date for the consulting and reporting requirements is necessary to allow time for ordering practitioners who are not already aligned with a qualified CDSM to research and evaluate the qualified CDSMs so they may make an informed decision. Although there will be another rulemaking cycle next year before the consulting and reporting requirement is effective as proposed on January 1, 2019, CMS is establishing this date through rulemaking this year because the agency expects practitioners and other stakeholders to begin preparing themselves to report on that date and, in response to public comment and stakeholder feedback, CMS wants to ensure all impacted parties have sufficient time to prepare to meet the requirements of this program.

AMIA Recommendation: AMIA recommends CMS delay AUC program requirements until 2019, as proposed, and seek information from stakeholders across 2018 to determine readiness. Due to the complexity of this multi-step process, we urge CMS to develop a series of pilot projects and tests one step at a time in order to ensure that the processes work as expected. While we support the use of computer-based decision support to guide image ordering as an exemplar of how informatics tools and applications can assist clinicians at the point-of-care, we also urge an informed implementation given the complexity of the AUC program. We additionally do not support a further extension at this time beyond the 2019/2020 dates proposed for phased implementation of the AUCs. It is important that clinicians have some level of certainty for planning for the roll-out of this complex program and we urge CMS to work with stakeholders during 2018 and 2019 to ensure smooth implementation.

⁵ Cusack CM, George H., Bloomrosen M., et al. The future state of clinical data capture and documentation: a report from AMIA's 2011 Policy Meeting. *Journal of the American Medical Informatics Association*, Volume 20, Issue 1, 1 January 2013, Pages 134–140, <https://doi.org/10.1136/amiajnl-2012-001093>

⁶ Ibid.

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Use of G-codes to Implement AUC reporting requirement

To implement the AUC requirement, CMS proposes to establish a series of HCPCS level 3 codes. These G-codes would describe the specific CDSM that was used by the ordering professional. Ultimately there would be one G-code for every qualified CDSM with the code description including the name of the CDSM. However, because the claims processing system can only recognize new codes quarterly, CMS may not be able to update the G-code descriptors simultaneously with the announcement of any new qualified CDSMs which is expected to occur in June of each year. To ensure that there is a code available to immediately describe newly qualified CDSMs, CMS proposes to establish a generic G-code that would be used to report that a qualified CDSM was consulted, but would not identify a specific qualified CDSM; clinicians would only be permitted to use this code if a more specific named code did not yet exist for that clinician's CDSM. Furnishing professionals would report this code temporarily until a specific G-code describing the newly qualified CDSM by name becomes available. CMS also proposes to establish a G-code to identify circumstances where there was no AUC consultation through a qualified CDSM. The description of this code would indicate that a qualified CDSM was not consulted by the ordering professional.

AMIA Recommendation: AMIA requests that CMS provide further detail on how these claims will be processed. AMIA is concerned that an additional G-code will add a layer of complexity, when AUC consultation may be sufficiently captured in EHR using the name of the CDSM, the NPI of the ordering provider, and an attestation of whether the order was compliant or non-compliant. We also ask that CMS clarify exactly what is the ordering clinicians' obligation during 2019, as it proposed not to make rendering provider payment contingent on including AUC indicators on claim forms. Beyond 2019, CMS should clarify how it intends to ensure accountability, and whether accountability for the accuracy of the reporting rests with ordering, or furnishing professionals.

Significant Hardship Exceptions to Consulting and Reporting Requirements

CMS proposes to remove as a criterion for a significant hardship exception for the AUC program the criterion specified in for those practicing for less than two years, while keeping the remaining listed categories including insufficient internet connectivity, extreme and uncontrollable circumstances, lack of control over availability of CEHRT and lack of face to face patient interaction. Further, they propose to amend the AUC significant hardship exception regulation to specify that ordering professionals who are granted re-weighting of the advancing care information performance category to zero percent of the final score for the year under MIPS due to circumstances that include the criteria listed above would be excepted from the AUC consultation requirement during the same year that the re-weighting applies for purposes of the MIPS payment adjustment.

AMIA Recommendation: AMIA supports CMS's proposed significant hardship exceptions and appreciates CMS's efforts to align hardship exceptions with MIPS requirements to the extent possible allowed by each program's rules.

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Alignment with Other Medicare Quality Programs

In the CY 2018 QPP proposed rule, CMS proposed to give MIPS credit to ordering professionals for consulting AUC using a qualified CDSM as a high-weight improvement activity for the performance period beginning January 1, 2018. Although the AUC program would not officially begin until January 1, 2019, CMS supports this proposed improvement activity because the first qualified CDSMs will be announced in conjunction with this proposed rule; therefore, ordering professionals will be able to begin consulting AUC using those tools. CMS is thus also considering how the AUC program could serve to support a quality measure under the MIPS quality performance category.

AMIA Recommendation: For purposes of MIPS, AMIA believes that use of a qualified CDSM is best left as an Improvement Activity only. AMIA supports programs and policies that increase and prioritize the development of outcome measures, in order to enable a shift away from process measures. Consulting AUC using a qualified CDSM should be a means to achieve better clinical outcomes, and should not be a quality measure outcome itself.

Proposed Modifications to the Satisfactory Reporting Criteria for Individual EPs and Group Practices for the 2018 PQRS Payment Adjustment

CMS is proposing to revise the previously finalized satisfactory reporting criteria for the CY 2016 PQRS reporting period to lower the requirement from 9 measures across 3 NQS domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. For individual EPs and group practices, this would apply to the following reporting mechanisms: claims, qualified registry (except for measures groups), QCDR, direct EHR product and EHR data submissions vendor product.

The NQS domain requirement would no longer apply. No changes are being proposed for the measures groups criteria. Additionally, CMS is also proposing that individual EPs and group practices reporting via claims or qualified registry, as applicable, would no longer be required to report a cross-cutting measure and that individual EPs and group practices reporting via QCDR would no longer be required to report an outcome or “high priority” measure (that is, for purposes of PQRS, a resource use, patient experience of care, efficiency/appropriate use, or patient safety measure). Lastly, CMS is proposing to lower the requirement to only 6 measures, if less than 6 measures apply to the individual EP or group practice, each measure that is applicable would need to have been reported.

AMIA Recommendation: AMIA supports CMS’s proposal to revise 2016 PQRS requirements so that they align with Quality Payment Program transition year requirements.

CQM Requirements for EPs and Groups under the Medicare EHR Incentive Program in 2016

CMS is proposing to change the reporting criteria for EPs and groups who chose to electronically report CQMs through the PQRS Portal for purposes of the Medicare EHR Incentive Program. Specifically, they are proposing to change the reporting criteria from 9 CQMs covering at least 3 NQS domains to 6 CQMs with no domain requirement. They are proposing this change so that the

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reporting criteria for the Medicare EHR Incentive Program would be in alignment with the modified requirement proposed for the final PQRS reporting period (2016) in section III.F. of this proposed rule, as well as the transition year of the Quality Payment Program.

CMS is proposing that an EP or group who satisfies the proposed reporting criteria may qualify for the 2016 incentive payment and may avoid the downward payment adjustment in 2017 and/or 2018, depending on the EP or group's applicable EHR reporting period for the payment adjustment year. This proposed change would help maintain alignment with PQRS.

AMIA Recommendation: AMIA supports CMS's proposal to revise Medicare EHR Incentive Program requirements so that they align with Quality Payment Program transition year requirements.

Request for Information on CMS Flexibilities and Efficiencies

CMS states it goals to reduce burdens on hospitals, physicians, and patients, improve the quality of care, decrease costs, and ensure that patients and their providers and physicians are making the best health care choices possible. To this end, they are inviting the public to submit their ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to better accomplish the goals of increasing quality of care, lowering costs, improving program integrity, and making the health care system more effective, simple and accessible.

In previous comments to CMS proposed rules, AMIA has offered several such ideas, as they relate to accelerating health and health care transformation through collecting, analyzing and applying data directly to care decisions. AMIA recommends that CMS better leverage data reported through MIPS and APMs to learn, continue to require certified EHRs for incentive program participation, and look to improve interoperability via promotion of value-based reimbursement.

The goal of data reporting is to learn, not simply to grade. Thus, as we continue with the transition to MIPS and APMs, CMS should leverage MIPS quality measures, Clinical Practice Improvement Activities (CPIAs) and Advancing Care Information (ACI) measures to inform key policy approaches to some of our most vexing challenges in healthcare, such as diagnosis error and health data interoperability. CMS should carefully examine the evidence base for CPIAs and ACI measures in the same way quality measures rely on evidence-based guidelines. To do this, CMS should engage organizations and experts to perform scientifically rigorous, peer-review studies to determine which requirements should be retained in future years.

As mentioned in the above comments, AMIA also recommends that CMS continue to require use of certified EHR technology to participate in incentive programs. While we support flexibilities for hospitals and clinicians that have not fully implemented 2015 Edition CEHRT, we strongly believe that providers must upgrade certified EHRs in a timely fashion to sustain and further encourage IT-enabled care delivery.

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In addition, CMS should review documentation requirements to ensure that only needed information is required, that it can be collected in the least burdensome manner possible, and that requirements are minimized, as applicable, across federal programs. CMS should also look to reduce direct and indirect burdens associated with a focus on measurement of use of specific health IT functionalities, which can impair usability and limit or distort workflows, as well as creating burdensome uncertainty for providers regarding audits. For example, our pediatrician members who report on the Medicaid EHR Incentive program note significant burden to participation, given high Medicaid eligibility hurdles (20% of encounters), and the need to report to agencies in 56 states and territories – all with small differences in reporting requirements. These issues pose a challenge to vendors of pediatric EHR software, they frustrate pediatric participation in the program who are dealing with audits that vary significantly from state to state, and they undermine the goals of the program.

Finally, CMS should encourage increased data exchange and interoperability whenever possible. It should thus seek out and work with its federal agency partners to identify technical standards that would facilitate the exchange of information between third party intermediaries.