



September 6, 2016

The Honorable Andrew M. Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
Submitted electronically <http://www.regulations.gov>

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical
Center Payment Systems

Dear Acting Administrator Slavitt:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the CY 2017 Hospital OPPS and Medicare ASC proposed rule.

AMIA is the professional home for more than 5,000 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.

Below, we provide our specific comments for the proposals in this rule related to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. We urge the agency to consider our comments and criticisms as constructive, and with the aim of helping CMS move toward a more desirable, holistic approach of improving care through robust uses of health IT and other informatics tools.

Proposed Changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

AMIA has strong interest in ensuring that the EHR Incentive Program is successful for stakeholders and the program encourages responsible use of information technology and other informatics tools to improve healthcare delivery. We believe that any changes to requirements under the EHR Incentive Program should help to promote flexibility, particularly in the Medicare landscape as we work to transition from the Medicare EHR Incentive Program to participation in the MIPS and APMs. In addition, we further recommend that CMS establish a regular cadence of updates/revisions to eCQMs, ensuring adequate time is allowed for implementation of revisions by

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both the vendor and provider; and ensure that all information and tools located in the eCQI Resource Center are complete and up-to-date.

Proposed Revisions to Objectives and Measures for Eligible Hospitals and Critical Access Hospitals (CAHs)

CMS proposes to eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program for 2017 and subsequent years in an effort to reduce reporting burden for eligible hospitals and CAHs, as CMS considers these objectives and measures to be topped out.

AMIA Recommendation: AMIA generally supports reducing reporting burden and therefore supports eliminating the CDS and CPOE objectives and measures as CMS considers these objectives and measures to be “topped out.” We also support CMS’ effort to ensure that the hospital reporting requirements are as consistent as possible with the EP requirements, which will minimize burden and confusion among both vendors and clinicians. Additionally, we agree that “eligible hospitals and CAHs should continue to independently measure and track activities related to the CDS objective and measures for their own quality improvement goals or preferences and agree with CMS that the functionality should continue as part of the 2015 Edition of CEHRT.”

Reduction of Measure Thresholds for Eligible Hospitals and CAHs for 2017 and 2018

CMS is proposing to reduce a subset of the thresholds for eligible hospitals and CAHs attesting under the Medicare EHR Incentive Program for EHR reporting periods in calendar year 2017 for Modified Stage 2 and in calendar year 2017 and 2018 for Stage 3.

AMIA Recommendation: AMIA generally supports CMS’ proposals related to the reduction of reporting thresholds for certain Modified Stage 2 objectives and measures for 2017 and Stage 3 objectives and measures for 2017 and 2018. However, we continue to emphasize our concern over whether the structure of these objectives and measures – which use a numerator/denominator paradigm for health IT process measures – is associated with improved outcomes. In addition, CMS’ proposed changes in measurement logic, which are not likely to be finalized until the fall, is a challenge for vendors and healthcare providers alike to implement by January 1, 2017, assuming a full-year reporting period. We also have concerns that the hospital requirements are diverging for Medicaid and Medicare and urge CMS to seek over relatively short order to harmonize between meaningful use and applicable MIPS criteria and between Medicare and Medicaid. The costs for both provider and vendors of increasing fragmentation are likely to be significant.

CMS is also seeking public comments on how measures of meaningful use under the EHR Incentive Program can be made more stringent in future years, consistent with the requirements of section 1886(n)(3)(A) of the Act.

AMIA Recommendation: CMS should augment future measures of meaningful use based on proven functionalities, supported with clear evidence that such functionalities will improve care to

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patients. Future years of the program should seek to propagate new uses of health IT based on implementation experience across various settings, geographies and patient populations – not reflexively seek to usher unproven or unpiloted functionalities nationwide. Further, we encourage CMS to seek measures that benefit population health and research without encumbering individual patients or their clinicians. CMS should engage with national organizations, such as AMIA, to determine what functionalities are demonstrating value and evaluate whether such functionalities could and should become national requirements.

Given experience to-date, CMS should not look to update requirements for the EHR Incentive Program until at least 2021, providing stability and consistency, year-over-year, to clinicians looking to optimize their technology beginning in 2018. In addition, the increased “stringency” should focus more on outcomes than simply adding more measures with higher thresholds.

Proposed Revisions to the EHR Reporting Period in 2016 for EPs, Eligible Hospitals and CAHs

CMS has received feedback that more time is needed to accommodate some of the updates from the 2015 EHR Incentive Programs Final Rule. In response to these concerns, CMS is proposing to change the EHR reporting periods in 2016 for returning participants from the full CY 2016 to any continuous 90-day period within CY 2016. Therefore, all EPs, eligible hospitals and CAHs may attest to meaningful use for an EHR reporting period of any continuous 90-day period from January 1, 2016 through December 31, 2016.

In connection with CMS’ proposal to establish a 90-day EHR reporting period in 2016, CMS is proposing a 90-day reporting period for clinical quality measures (CQMs) for all EPs, eligible hospitals, and CAHs that choose to report CQMs by attestation in 2016. CMS is proposing that providers may either:

- Report CQM data by attestation for any continuous 90-day period during calendar year 2016 through the Medicare EHR Incentive Program registration and attestation site; or
- Electronically report CQM data in accordance with the requirements established in prior rulemaking.

AMIA Recommendation: AMIA supports this proposal. Experience with MU has indicated that 90-day reporting periods have benefited clinicians without compromising their commitment to using IT to improve care. We agree that this proposal is particularly helpful for eligible hospitals and CAHs who are in the process of updating their IT systems without having to worry about their systems being able to collect data for reporting for a full CY. As the proposed 90-day reporting period would occur this year, we encourage CMS to implement this proposal as soon as possible to allow as much time as possible for EPs, eligible hospitals, and CAHs to take advantage of this proposed reporting period.

Proposal to Require Modified Stage 2 for New Participants in 2017

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CMS is proposing that any EP or eligible hospital new participant seeking to avoid the 2018 payment adjustment by attesting for an EHR reporting period in 2017 through the EHR Incentive Program Registration and Attestation system, or any CAH new participant seeking to avoid the FY 2017 payment adjustment by attesting for an EHR reporting period in 2017 through the EHR Incentive Program Registration and Attestation System, would be required to attest to the Modified Stage 2 objectives and measures.

AMIA Recommendation: We support this proposal and concur with CMS' rationale.

Proposed Significant Hardship Exception for New Participants Transitioning to MIPS in 2017

In the MIPS and APMs Proposed Rule, CMS proposed calendar year 2017 as the first MIPS performance period. As established in the 2015 EHR Incentive Programs Final Rule, 2017 is also the last year in which new participants may attest to meaningful use to avoid the 2018 payment adjustment. Due to this overlap, and for other reasons, CMS is proposing to allow certain EPs to apply for a significant hardship exception from the 2018 payment adjustment. CMS is limiting this proposal only to EPs who have not successfully demonstrated meaningful use in a prior year, intend to attest to meaningful use for an EHR reporting period in 2017 by October 1, 2017 to avoid the 2018 payment adjustment, and intend to transition to MIPS and report on measures specified for the advancing care information performance category under the MIPS in 2017.

This proposal is contingent upon CMS' proposal in the MIPS and APMs Proposed Rule to establish 2017 as the first performance period of the MIPS. In the event CMS decides not to finalize that proposal, and instead adopt a different performance period for the MIPS that does not coincide with the final year for EPs to attest to meaningful use under the Medicare EHR Incentive Program, CMS may determine that this proposed significant hardship exception is not necessary.

AMIA Recommendation: AMIA generally support CMS' proposal to allow certain EPs to apply for a significant hardship exception from the 2018 payment adjustment. From an operational standpoint, we believe it is necessary to accommodate the overlap in reporting/performance periods as we transition from the Medicare EHR Incentive Program to participation in the MIPS.

Proposed Modifications to Measure Calculations for Actions Outside the EHR Reporting Period

FAQ 8231 states that for all meaningful use measures, unless otherwise specified, actions may fall outside the EHR reporting period timeframe but must take place no earlier than the start of the reporting year and no later than the date of attestation.¹ CMS has received feedback from stakeholders that this open-ended timeframe leads to confusion. To minimize confusion as well as to be consistent with incorporation of data from one EHR reporting period, CMS is proposing that, for all meaningful use measures, unless otherwise specified, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full

¹ https://questions.cms.gov/faq.php?isDept=0&search=8231&searchType=faqId&sub_mitSearch=1&id=5005

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calendar year, within the calendar year in which the EHR reporting period occurs. For example, if the EHR reporting period is any continuous 90-day period within CY 2017, the action must occur between January 1 and December 31, 2017, but does not have to occur within the 90-day EHR reporting period timeframe.

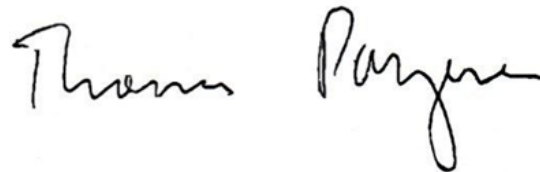
AMIA Recommendation: We agree with CMS that this proposal is generally reasonable and would partially reduce confusion in reporting. However, we urge CMS to provide sub-regulatory guidance that would clearly describe scenarios where actions could occur within the calendar year, but outside of the 90-day reporting period when the provider has chosen to utilize a 90-day reporting period to satisfy the requirements as well as any remaining circumstances where numerator increments can occur after the end of the reporting year. More generally, as discussed above, we are very concerned that CMS is making measurement logic changes so late in the 2017 cycle, leaving very little time for providers and vendors to update measurement logic for 2017 from Final Rule issuance.

We hope our comments, attached below, 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,



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