



June 13, 2017

The Honorable Seema Verma  
Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1677-P  
Submitted electronically <http://www.regulations.gov>

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates

Dear Administrator Verma:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on the FY 2018 Hospital Inpatient Prospective Payment Systems 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.

Generally, AMIA is supportive of the proposed flexibilities afforded to providers for quality reporting and quality payment programs, for example the 90-day EHR Incentive Program reporting period, and reduction of required quality measures. Given the need to upgrade to 2015 Edition Certified EHR Technology, and the changing requirements associated with the program in 2018, we anticipate that providers would benefit from additional time to implement, test and adjust workflows. Likewise, the reduction of eCQMs will better enable hospitals to work towards the goal of more efficient and seamless electronic collection and submission of quality measures.

Below, we provide our specific comments for the proposals in this rule related to electronic clinical quality measure (eCQM) reporting requirements for the Hospital IQR and Medicare EHR Incentive Programs for hospitals and other Meaningful Use (MU) requirements under the Medicare and Medicaid 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 use of health IT and other informatics tools.

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### Proposed Revisions to Hospital IQR Program

For the CY 2017 reporting period/FY 2019 payment determination, CMS proposes to require hospitals to report on at least six of the available eQMs, instead of eight as previously finalized, and submit two self-selected quarters of data, instead of one full calendar year of data as previously finalized. Additionally, CMS proposes that for the CY 2018 reporting period/FY 2020 payment determination, hospitals be required to report on at least six of the available eQMs, and report the first three quarters of the CY 2018 reporting period.

**AMIA Recommendation:** AMIA generally supports reducing reporting burden and therefore supports the reduction of required eQMs. We also support CMS' effort to ensure that the hospital reporting requirements are aligned with the EP requirements for the Merit-based Incentive Payment System (MIPS) requirements, which will minimize burden and confusion among both vendors and clinicians. We do urge that CMS allow use of any two quarters during 2018 (as is proposed for 2017) to allow hospitals to reuse data extraction processes in 2018 that were used in 2017 and provide more flexibility and time for hospitals to upgrade and fully implement 2015 CEHRT.

### 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 quality of care and provider flexibility, particularly in the Medicare landscape as we work to transition on the clinician-side from the Medicare EHR Incentive Program to participation in the MIPS and APMs.

#### *Proposed Modifications to the CQM Reporting Requirements for the Medicare and Medicaid EHR Incentive Programs*

CMS proposes that for eligible hospitals and CAHs demonstrating meaningful use for the first time in 2017, or that have demonstrated meaningful use in any year prior to 2017, the reporting period be two self-selected quarters of CQM data in CY 2017. Additionally, CMS is proposing that eligible hospitals and CAHs only participating in the EHR Incentive Program, or participating in both the EHR Incentive Program and the Hospital IQR Program, would report on at least 6 self-selected of the available CQMs.

For CY 2018, CMS is proposing that for eligible hospitals and CAHs who report CQMs electronically and who demonstrate meaningful use for the first time in 2018 or have demonstrated meaningful use in any year prior to 2018, the reporting period would be the first 3 quarters of CY 2018. For eligible hospitals and CAHs that report CQMs by attestation under the Medicare EHR Incentive Program because of electronic reporting not being feasible, and for eligible hospitals and

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CAHs that report CQMs by attestation under their state’s Medicaid EHR Incentive Program, the CQM reporting period will be the full CY 2018 (consisting of 4 quarterly data reporting periods). They are also proposing an exception to this full-year reporting period for eligible hospitals and CAHs demonstrating meaningful use for the first time under their state’s Medicaid EHR Incentive Program; under this exception, the CQM reporting period is any continuous 90-day period within CY 2018.

**AMIA Recommendation:** AMIA supports CMS’s continued effort to align the Medicare and Medicaid EHR Incentive Programs and the Hospital IQR Program to reduce confusion and reporting burden among participants. Further, we support flexibilities offered to hospitals who have not fully implemented 2015 Edition CEHRT by the end of Q1 – by way of allowing them to attest on a quarterly basis. As proposed above, we believe that hospitals and CAHs should be able to report on any two quarters during 2018 and that this flexibility be extended to those that will be attesting as well given that they will still need CEHRT to collect applicable data and generate CQM results for attestation.

#### *2015 Certified EHR Technology*

CMS proposes to maintain the requirement that EHR technology be certified to the 2015 Edition for CQM reporting. Furthermore, they are proposing that an EHR certified for CQMs under the 2015 Edition certification criteria would not need to be recertified each time it is updated to a more recent version of the CQMs. CMS’s analysis has also showed that progress toward certification and upgrade of systems should enable EPs that attest directly to a State for the State’s Medicaid EHR Incentive Program and eligible hospitals and CAHs attesting to CMS or the State’s Medicaid EHR Incentive Program to upgrade systems to the 2015 Edition and successfully attest for an EHR reporting period in 2018.

**AMIA Recommendation:** AMIA agrees with CMS’s analysis, and that there shall be no delay with regards to EHR certification requirements. We anticipate that this approach will encourage continued and sustained resources on IT-enabled care delivery. Improvements to the 2014 Edition, in terms of functionality and capability, need to propagate across the industry, and evidence suggests government-imposed incentives will increase the likelihood this occurs more uniformly.

#### *CQM Reporting for Medicaid EHR Incentive Program*

CMS proposes changing the CQM reporting period for EPs who report CQMs electronically in the Medicaid EHR Incentive Program to a minimum of a continuous 90-day period during CY 2017. The reporting period for CQMs for EPs who choose to attest rather than report electronically, and who have demonstrated meaningful use in a previous program year under the EHR Incentive Program would remain one full year (CY 2017). The CQM reporting period for the Medicaid EHR Incentive Program in 2018 for EPs that have demonstrated meaningful use in a previous program year would remain one full year (CY 2018) to align with the corresponding performance period in MIPS for MIPS eligible clinicians.

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CMS is also proposing to align the specific CQMs available to EPs participating in the Medicaid EHR Incentive Program with those available to clinicians participating in MIPS who submit CQMs through their EHR. CMS is additionally proposing to eliminate the requirement to report on CQMs across 3 of the 6 NQS domains that existed in previous years of the Medicaid EHR Incentive Program, for improved alignment with the data submission criteria for the MIPS quality performance category. Medicaid EPs would be required to report on any six measures that are relevant to the EP's scope of practice.

**AMIA Recommendation:** AMIA supports CMS's continued efforts to align the Medicaid EHR Incentive Program the MIPS to reduce confusion and reporting burden among participants. As proposed above, we believe this flexibility be extended to those that will be attesting as well given that they will still need CEHRT to collect applicable data and generate CQM results for attestation.

#### *EHR Reporting Period in 2018*

CMS is proposing to modify the EHR reporting periods in 2018 for new and returning participants attesting to CMS or their State Medicaid agency from the full year (CY 2018) to a minimum of any continuous 90-day period within CY 2018. The reason for this is that CMS expects a majority of EPs, eligible hospitals, and CAHs participating in the EHR Incentive Programs to be ready to begin using 2015 Edition CEHRT in CY 2018, but knows there will still be some who will not be ready and will require a longer timeframe for successful implementation. In addition, it is likely that there will be a proportion of them that have the technology implemented in time for the beginning of CY 2018 who would similarly benefit from additional time to implement new processes and workflows supporting their use of certified EHR technology in the EHR Incentive Program.

**AMIA Recommendation:** Again, AMIA agrees with CMS's reasoning, and supports the additional flexibility that will allow more EPs, eligible hospitals, and CAHs to successfully participate in the EHR Incentive Program.

#### *Decertification of CEHRT*

As mandated by Section 4002 21st Century Cures Act, CMS is proposing to add a new exception from the Medicare payment adjustments for EPs, EHS, and CAHs unable to comply with the requirement for being a meaningful user because their CEHRT has been decertified under the ONC Health IT Certification Program.

**AMIA Recommendation:** AMIA is pleased that this provision of the 21st Century Cures Act will be implemented. Additionally, CMS's 12-month timeframe preceding the applicable EHR reporting period, in which the certified EHR technology may have been decertified, is a reasonable one. AMIA looks forward to the timely implementation of other 21st Century Cures provisions, as well.

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## ICD-10 Coding Updates

The ICD-10 Coordination and Maintenance Committee is responsible for addressing updates to the ICD-10-CM and ICD-10-PCS coding systems, including approving coding changes, and developing errata, addenda, and other modifications to the coding systems to reflect newly developed procedures and technologies and newly identified diseases. It is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system. The Committee presented its coding change proposals at its 2017 public meeting, and invited feedback on the changes. While the deadline for commenting on such coding changes has passed, AMIA is nevertheless concerned about how the coding updates interfere with consistent clinical vocabulary maintenance.

Many of the ICD-10-PCS coding updates involve the addition of specificity, beyond what the 2017 version of the code description states. For example, in 2017, code 0J843ZZ is described as “Division of Anterior Neck Subcutaneous Tissue and Fascia, Percutaneous Approach.” However, in 2018, the description will be, “Division of Right Neck Subcutaneous Tissue and Fascia, Percutaneous Approach.” A core principle of clinical vocabulary maintenance is that the meaning of a code should not change over time.<sup>1</sup> When this principle is not adhered to, confusion can arise about the meaning of patient data stored using the code. This occurs because the meaning of the code to the person who selected it would have been based on a now-obsolete code description. AMIA is concerned that these coding updates will effectively corrupt large amounts of patient data already coded in ICD-10-PCS.

**AMIA Recommendation:** AMIA believes that clinical vocabulary maintenance should be a primary consideration of the Coordination and Maintenance Committee, before any further coding changes are proposed. We look forward to working with HHS and members of the Committee on how to prioritize code description considerations for the next fiscal year.

### *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

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<sup>1</sup> Cimino JJ. Desiderata for Controlled Medical Vocabularies in the Twenty-First Century. *Methods of information in medicine.* 1998;37(4-5):394-403. (esp. section 2.3, “Concept Permanence”)

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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.

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.

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](mailto:jsmith@amia.org) or (301) 657-1291. We look forward to continued partnership and dialogue.

Sincerely,

Handwritten signature of Douglas B. Fridsma in black ink.

Douglas B. Fridsma, MD, PhD, FACP,  
FACMI  
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Handwritten signature of Thomas H. Payne in black ink.

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