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June 25, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information [CMS-1694-P]

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) FY 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule. Our comments focus on the following sections:

- Proposed Changes to the Medicare and Medicaid EHR Incentive Programs
- Request for Information on Promoting Interoperability and Electronic Health Information Exchange
- Improving Patient Outcomes and Reducing Burden Through Meaningful Measures
- Requirements for Hospitals to Make Public a List of Their Standard Charges

The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

I. Proposed Changes to the Medicare and Medicaid EHR Incentive Programs

Updated Program Name and 90-day Reporting Period

ACP applauds CMS' focus on interoperability and improving patient access to health information as well as the subsequent renaming of the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability (PI) Programs to highlight this focus. As part of the updates to the PI Program in 2019, CMS proposes to maintain the 90-day EHR reporting period for both the 2019 and 2020 program years. New and returning participants will be required to report a minimum of any continuous 90-day period within each of the calendar years 2019 and 2020. The College believes that a 90-day reporting period for PI is a sufficient amount of time to capture the necessary information required and also allows flexibility for hospitals, critical access hospitals (CAHs), as well as participating physicians, upgrading or replacing their EHR systems to be able to select the 90 days of data that reflects the highest utilization. **ACP strongly supports the 90-day reporting period for the PI Program and recommends CMS consider maintaining the 90-day reporting period beyond 2020. This shorter PI reporting period allows for the opportunity to update or implement new and innovative technology throughout the course of the calendar year without the fear of negatively impacting performance data.**

2015 Certified Electronic Health Record Technology (CEHRT) Requirements in 2019

In the past, CMS has been flexible in letting eligible hospitals and clinicians use either the 2014 or 2015 Edition of CEHRT. The Agency is now proposing to require use of the 2015 CEHRT Edition for the CY19 reporting period. One of the specific functionalities required in the 2015 Edition is Application Programming Interfaces (APIs) – which will help the Agency promote their push for interoperability and the flow of information between physicians and patients (through their MyHealtheData Initiative – Blue Button 2.0). **The College supports the requirement for use of 2015 CEHRT in 2019 and agrees that moving to more up-to-date standards and functions is important and will better support the exchange of health information**. We would like to reiterate our previous concerns regarding the significant cost associated with implementation and the large amount of time these types of system upgrades take to roll out, including effectively deploying the new technology, staff training, and workflow adjustments – all leading to potential risk to patient health. **Therefore, we further recommend that CMS allow for at least six months, if not a full year, for physicians to implement the upgrades once the 2015 CEHRT is ready and available from their vendor.**

Proposed Measures and Scoring Methodology Under the Medicare PI Program

CMS is moving away from using measure thresholds and proposing a new performance-based scoring methodology for hospitals and CAHs participating in the PI Program in 2019. The new scoring methodology includes a combination of existing Stage 3 EHR Incentive Program measures as well as new measures divided into a smaller set of four (instead of six) objectives and scored based on performance and participation**.** Eligible hospitals and CAHs earning a total

of 50 points or more would satisfy the reporting requirement and earn an incentive payment and/or avoid a Medicare payment reduction. Instead of meeting specific thresholds for each of the measures within the PI Program, as in previous years, CMS is proposing a performance-based point system in which the numerator and denominator of each measure would translate to a performance rate for that measure and be applied to the total possible points. **ACP has outlined detailed recommendations[1,2] for removing thresholds for EHR-functional-use measures and applauds the Agency for moving in this direction. We hope that similar scoring methodology adjustments will be made to the PI program under the Quality Payment Program (QPP) as it will help to further align the EHR programs across the board.**

Application of Proposed Scoring Methodology and Measures Under the Medicaid Promoting Interoperability Program

CMS is not requiring States to adopt the new scoring methodology and measures for "Medicaid-only" PI Programs but instead allowing States to opt in by submitting a change request for approval by CMS. If states do not opt in to the new proposals, the scoring and objectives/measures will remain the same as they are listed in Stage 3. It is well known that Medicaid EPs take care of the sickest and most disadvantaged population of patients and are the clinicians most vulnerable to stringent regulatory requirements. The Stage 3 requirements include burdensome thresholds and measures that CMS has determined to be duplicative and burdensome as outlined in their proposed changes to the measures and scoring methodology in the IPPS rule. The College believes there is still work to be done in order for the proposed PI program to truly promote interoperability and assist practices in applying health IT to improve the quality and value of care, but it is unfair that EPs participating in the Medicaid EHR Incentive Programs would have to meet outdated Stage 3 requirements in 2019 if their state does not opt in. **Therefore, the College recommends CMS modify the Stage 3 requirements to align with the proposed PI requirements for clinicians participating in the "Medicaid-only" PI Program.**

Promoting Interoperability Program Future Direction

CMS continues to consider changes to the PI Program which support a variety of the Department of Health and Human Services (HHS) goals and believes a focus on interoperability and simplification will reduce clinician burden while allowing flexibility to pursue innovative applications that improve care delivery. One strategy CMS is exploring is creating a set of priority health IT activities that would serve as alternatives to the PI Program measures, much like what ACP recommended in previous comments on the MU program and ACI performance category. ACP applauds CMS for their proposals for the future direction of the PI program (for eligible hospitals and CAHs) as they align with ACP's previous recommendations for the ACI (now PI) program under QPP, and we hope to see similar proposals in the 2019 QPP rule**. If these proposals are finalized, it is important that any new or existing alternative health IT activities are clearly defined and participation in these activities promotes the use of health IT to improve care delivery and supports practical interoperability.**

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[1] https://www.acponline.org/acp_policy/letters/acp_mu_stage_3_comments_2015.pdf
[2] https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

II. Request for Information on Promoting Interoperability and Electronic Health Information Exchange

In an effort to further promote interoperability and electronic health information exchange, CMS is considering revisions to the current CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid Programs (Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care Facilities).

The College believes that updating the requirements within CoPs is a good option when/if the requirements for interoperability are easy to measure and do not create new and ongoing reporting burdens; however, the College still has concerns that CMS is not focusing on the useful, practical aspects of interoperability that would truly enhance high-value care. When looking at clinical data exchange in the context of routine care delivery, CMS' policies are on the right track – specifically, policies allowing physicians to constrain the information in the summary care record to support transitions of care; allowing physicians to use their judgment in deciding which items present on the problem list, medical history list, or surgical history list; and allowing hospitals and CAHs to use any document template within the consolidated clinical document architecture (C-CDA) standard to ensure the relevant information is included. **The College believes these proposals should apply in all routine care delivery situations as an industry-wide best practice – not just related to participation in the PI Program or any other particular Medicare program.**

However, when discussing interoperability more broadly, including other purposes of clinical data exchange outside of routine care delivery, (e.g., Health Information Exchange [HIE] repositories, clinical data registries, private payer billing and payment requests, and patient requests), we believe there is a fundamental misconception that sending all data everywhere is promoting or enhancing interoperability. From a technical perspective, once the full set of clinical data is sent from the source, it is considered historical data. Something may have changed since the latest copy was received that would cause a change in decision making about the patient. It would be unsafe to make clinical decisions based upon the latest C-CDA without going back to the source to ask if there is anything new that is relevant. One example where this could be an issue is if certain payers plan to develop and practice care delivery plans based on this reported, historical data. And unfortunately, a system in which an abundance of clinical information is consistently, securely, and electronically transferred still does not address the burdensome issues clinicians face with their electronic health records (EHRs). **It is important to recognize that access to every aspect of a patient's information does not help with the issue of access to useful and actionable information at the point of care.**

III. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

The College appreciates that CMS has prioritized reducing administrative and regulatory burden and we believe the Meaningful Measures Initiative is a great stride in the direction to reduce the regulatory burden on the health care industry, lower health care costs, and enhance patient

care. As a component of the Agency-wide Patients Over Paperwork Initiative – the Meaningful Measures Initiative aims to distinguish the highest priority areas for quality measurement and quality improvement while remembering the true objective to assess the core quality of care issues most vital to improving patient outcomes. Additionally, the initiative addresses an approach to managing quality measurement that will improve operational efficiencies and decrease costs, including collection and reporting burden, while producing quality measurement that is more focused on meaningful outcomes.

Through this initiative, the College strongly recommends CMS consider developing a measure indicating early mobility to balance the implications of the falls prevention measure. Additionally, if data is inadequate to validate the implications of removing the falls indicator from the list of Hospital Acquired Conditions (HACs), ACP advocates for CMS to institute a data collection process to describe how implementation of an early mobilization measure interacts with the falls indicator. Regarding the falls indicator included in the list of potentially avoidable HACs, the College agrees that implementation may preclude early mobilization of hospitalized patients and may give rise to post-hospital syndrome; we are also concerned that removing this indicator from the list of avoidable HACs could result in serious injury. Falls with injury should be avoided in the hospital and the best strategy for falls prevention includes early mobilization. The College is supportive of the Agency's efforts to develop measures that are evidence-based and operate within existing clinical workflows so as not to increase reporting burden. We believe that stakeholder engagement is critical to the measure development and data collection process and we look forward to working with CMS on these important efforts.

IV. Requirements for Hospitals to Make Public a List of Their Standard Charges

ACP supports transparency of reliable and valid price information, expected out-of-pocket costs, and quality data that allows consumers, physicians, payers, and other stakeholders to compare and assess medical services and products in a meaningful way. The College agrees action should be taken to increase protection for patients who find themselves subject to unexplained or surprise bills through no fault of their own, particularly those incurred during emergency or other medical situations in which additional services are provided by out-of-network clinicians without the patient's prior knowledge.

However, the complexity of medical billing can make it difficult or misleading to come up with an "average" price for a particular service. Prices can vary widely based on information unique to the individual patient and visit, including comorbidities, necessary follow-up care or tests, and site of service, among a range of other factors. Pricing for self-pay patients and those privately insured are determined through two distinct processes that would require separate approaches to price transparency. Beyond that, individual hospital-payer contracts can bundle services, treatments, and drugs completely differently, making direct, national, or even regional price comparisons difficult. What matters most to the patient is not the total cost of a service; it is their own out-of-pocket responsibility. Requiring hospitals to publicly post prices would be operationally challenging and may not ultimately be informative for patients. ACP recommends

pursuing several more immediate steps to better leverage existing coverage and cost information in a transparent way to help patients to make informed choices about their care.

Health plans are in the best position to communicate important coverage information that impacts their customers' total out of pocket cost. **The College urges CMS to encourage health plans to share information with clinicians and patients regarding important coverage, cost, and quality information, such as whether a clinician is in-network or out-of-network.** Integrating cost, quality, and coverage data into electronic health records systems, quality clinical data repositories, regional health information exchanges, or all payer claims databases, would help physicians to be more effective partners in helping patients to navigate this information and make informed, cost-effective decisions about their care. The growing prevalence of narrow network plans exacerbates this problem and should be separately studied and addressed. ACP also supports legislative action at the state level to prohibit "gag clauses" and similar contractual arrangements that interfere in the transparency of relevant health data. ACP also supports the development of alternative payment models, which show promise in aligning financial incentives to facilitate enhanced communication and coordination between multiple providers and cost-effective referral patterns to high-value, in-network providers.

Price should never be used as the sole criterion for selecting a physician or service; it should always be accompanied by quality information critical to understanding the total value of care, such as metrics about patient safety and health outcomes. If not, patients may simply defer to the lowest-cost providers, which could put them in a vulnerable position. At the same time, quality data released should be thoroughly vetted before being released to the public so as not to adversely penalize providers who care for vulnerable patient populations that are predisposed to worse outcomes, so as not to exacerbate existing social determinants of health. All information should be communicated in a readily accessible way to patients at all levels of health literacy and presented in a way that clearly articulates which services, treatments, and prescription drugs are included (and not included) in a given price, so that patients can make meaningful comparisons across settings of care and providers. Patients should also be made aware of the possibility of added costs due to common complications or add-on treatments. Releasing pricing information that is taken out of context, flawed, or incomplete has the potential to be more harmful to patients than lack of information.

As CMS looks to possibly regulate in this complex and sensitive pricing environment with the potential for wide-reaching implications on payers, providers and patients alike, **the College recommends a graduated, targeted approach to any new price transparency initiatives and frequent consultation with stakeholders throughout the process.** Gradual implementation will help to minimize the potential for major disruptions to physician payments and therefore patient care.

ACP appreciates the opportunity to comment on the CMS 2019 IPPS Proposed Rule and provide feedback on the Meaningful Measures initiative, the included RFI to promote interoperability and health information exchange, and future price transparency efforts. Thank you for your time and consideration. Please contact Brian Outland, PhD, by phone at 202-261-4544 or e-mail at boutland@acponline.org if you have questions or need additional information.

Sincerely,

Jacqueline W. Fincher, MD, MACP
Chair, Medical Practice and Quality Committee
American College of Physicians