



Physicians Caring for Texans

June 25, 2018

Seema Verma, Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1694-P
PO Box 8011
Baltimore, MD 21244-1850

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 2019 Rates; Proposed Quality Reporting Requirements for Specific Providers; Proposed Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims

Dear Administrator Verma:

On behalf of the Texas Medical Association (TMA) and our 51,000-plus physician and medical student members, thank you for the opportunity to comment on areas of the Hospital Inpatient Prospective Payment Systems proposed policy changes published in the *Federal Register* on May 7, 2018.

TMA recognizes the challenges facing health care stakeholders as electronic medical record systems become near-ubiquitous. TMA appreciates the Centers for Medicare & Medicaid Services' (CMS') attempt to reduce administrative burden and urges CMS to continuously seek efficiency in all of its programs. What follows are TMA comments on the proposed policy changes that impact physicians.

Section VIII.D.2. Renaming the EHR Incentive Program

Comment: While TMA appreciates that CMS wants to have an increased focus on interoperability and improving patient access to health information, we do not believe changing the name to Promoting Interoperability Program is necessary. The name change adds to the confusion of already complex programs that include more than promoting interoperability.

Section VIII.D.4. Proposed Revisions to the EHR Reporting Period in 2019 and 2020

Comment: TMA agrees with CMS' proposal to allow a 90-day reporting period in 2019 and 2020 for the Medicaid Promoting Interoperability Program. TMA encourages CMS to take this proposal a step further and apply it to all reporting programs such as the Quality Payment Program (QPP) for the life of the program. In any given year, most organizations experience technical interruptions caused by

software upgrades, system changes, and a host of other issues that create an undue burden when tracking measures for a full calendar year.

Section: VIII.D.6.d.(2) Proposed Removal of the Patient-Generated Health Data Measure

Comment: TMA agrees with CMS that the Patient-Generated Health Data measure should be removed to reduce complexity and focus on the goal of using advanced EHR technology and functionalities to advance interoperability. TMA requests that in addition to removing this measure for eligible hospitals and critical access hospitals, CMS also remove it for eligible clinicians.

Section: VIII.D.7. Proposed Application of Proposed Scoring Methodology and Measures Under the Medicaid Promoting Interoperability Program

Comment: TMA appreciates the flexibility CMS is giving states to adopt a new scoring methodology for the Medicaid Promoting Interoperability Program. TMA cautions CMS that states should have two narrow options: (1) continue with the existing meaningful use measures, or (2) adopt the Medicare QPP measures. Anything beyond those options creates confusion and burden for all stakeholders. Physicians practicing in cities that cross state lines, e.g., Texarkana, may have to comply with multiple unaligned reporting programs that have data collection requirements that are different and therefore burdensome.

Section: VIII.D.8. Promoting Interoperability Program Future Direction

Comment: TMA appreciates CMS' desire to reduce administrative burden and its support of aligning the QPP programs. In the proposed rule, CMS cites as an example a question of whether participation in the Trusted Exchange Framework and Common Agreement (TEFCA) should be considered a health information technology activity that could count for credit within the health information exchange objective in lieu of reporting on measures for this objective. Generally, TMA agrees with such an approach; however, only a draft of TEFCA has been distributed, thus reducing the ability to agree with confidence.

TMA remains concerned about interface connection and maintenance fees that EHR vendors charge to physicians. For many years, TMA has advocated for universal use of extensible markup language — XML — or a similar standard (e.g., Fast Healthcare Interoperability Resources, or FHIR) for all EHR data as a way of exchanging meaningful health data, as is used in accounting and other industries. Universal common encoding of all data elements would permit disparate systems to share and consume information much more easily. Data transferred to a receiving EHR could be correctly understood within the system to give it meaning and make it useful.

A simple example that is not currently possible, even in some cases if they use the same vendor, is transmitting pacemaker information and settings via discrete data between a hospital and the follow-up physician's EHR. Standardized coding of data elements would make this easy and cheap. This would allow the information in the receiving EHR to be searchable, extracted for reports (such as medication or device recalls), and available for clinical decision support. A more complex example of the benefits of standard tagging in an EHR database is where a physician desires to change EHRs. If the receiving EHR has the same functionality as the sending EHR, standard tagging would make it possible to move from one EHR to another almost instantaneously and at little to no cost.

It is time that CMS, the Office of the National Coordinator for HIT, and the National Institute of Standards and Technology push for such a standard to make the sharing of data safer, faster, and cheaper. This will significantly reduce administrative burden.

Section: XI. Proposed Revisions Regarding Physician Certification and Recertification of Claims

Comment: TMA supports CMS' suggestion that physicians not have to repeat statements or certification of medical necessity when the statement already appears elsewhere in the record. CMS correctly surmises that the duplication of statements or location of information is unnecessary, obsolete, and excessively burdensome to physicians.

We appreciate the opportunity to comment. Should you have any questions, do not hesitate to contact Shannon Vogel at TMA by calling (512) 370-1411 or emailing shannon.vogel@texmed.org.

Sincerely,

A handwritten signature in black ink that reads "Matt Murray". The signature is written in a cursive, slightly slanted style.

Matthew Murray, MD
Chair, ad hoc Committee on Health Information Technology
Texas Medical Association