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January 25, 2019

Don Rucker, M.D.
National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street, SW
Washington, DC 20201

Re: Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Dr. Rucker:

On behalf of nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to respond to the Office of the National Coordinator for Health Information Technology's (ONC's) draft strategy on ways to reduce burden for providers using health information technology (IT) and electronic health records (EHRs).

ACEP supports the Trump Administration's commitment to eliminating barriers that impede our ability to provide the best possible care to our patients. Emergency physicians play a critical role in our health care system, serving as the safety net in our communities. However, in general, it is challenging for us to provide comprehensive care to patients who arrive in our emergency departments (EDs) without a medical record that we can easily access. In many cases, we see patients with acute conditions who we have never seen before. With limited information, we deal with life and death situations and must make near-instantaneous critical decisions about how to treat our patients. Therefore, we are particularly anxious to work with hospitals toward the goal of interoperable EHRs that will open the door to more comprehensive patient information sharing across sites of care. Linking disparate EHRs will allow us to make more informed decisions and will significantly enhance timely communication with patients, community physicians, and other caregivers. To that end, we support Medicare policies that promote our ability to receive and exchange information about our patients.

In general, ACEP is supportive of the main recommendations included in the draft strategy. We also appreciate the efforts the Administration has already taken to reduce provider burden and to improve the usability and exchange of information. However, we were disappointed that the strategy did not at all address the effectiveness of qualified clinical data registries (QCDRs) or what the Administration can do to continue to encourage these as a way of reporting quality measures, as the Medicare Access and CHIP Reauthorization Act (MACRA) intended. Please find our specific comments on the draft strategy below.

WASHINGTON, DC OFFICE
2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
www.acep.org

Interoperability for Hospital-based Clinicians

One of the recommendations in the draft strategy is to continue to promote national policies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden. As emergency physicians working in hospitals, we should have access to all the patient's data from the hospital's EHR. However, in many cases, this does not occur. For example, a large number of emergency physicians and groups that use ACEP's QCDR, the Clinical Emergency Data Registry (CEDR), to report quality measures do not receive any data from their hospitals. Data from hospitals could include critical information such as medications, labs, and other test results for patients. Without these data elements, the measures cannot be fully calculated and scored. Hospitals claim that they cannot share the data for privacy and security purposes, but CMS has indicated that there are no regulations that impede hospitals from doing so. **Since this is a serious issue for hospital-based clinicians, we would like to CMS to include in the final strategy what the agency can specifically do to help improve the flow of information.**

Reducing Documentation Burden

In the draft strategy, HHS references the documentation changes made in the Calendar Year (CY) 2019 Physician Fee Schedule and Quality Payment Program final rule that became effective at the start of the year. Like all physicians, we spend much too long entering information into EHRs. This is precious time that we could be spending focused directly on patient care. Seconds matter when it comes to treating patients experiencing life-threatening emergencies, and eliminating duplicative requirements is extremely beneficial to both emergency providers and their patients. We strongly support not having to re-document specific data already present in the medical record or information that may have previously been inputted by residents or other members of the medical team. We encourage CMS to continue reducing documentation requirements through its Patients over Paperwork initiative, and we hope that other payers follow CMS' lead and only require documentation when it truly adds clinical value.

The draft strategy also recommends waiving specific documentation requirements in alternative payment models (APMs). ACEP agrees that CMS could do more to promote participation in APMs, and reducing documentation burden could be a useful incentive. Many emergency physicians are ready to participate in APMs, but they have few, if any, opportunities to fully participate in them. ACEP developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM), which the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently recommended to the HHS Secretary for full implementation. The use of certified electronic health record technology (CEHRT) is essential for the AUCM's goal of improving care coordination for patients and is an integral part of the model's overall quality strategy.

Health IT Usability and User Experience

ACEP agrees with many of the draft strategy's recommendations about how to improve the usability of data, and we are encouraged that HHS has identified this as a significant issue. EHRs contain vast amounts of data, and we need better tools to be able to utilize that data efficiently and effectively to serve our patients better. The ability to find information quickly is most critical when emergency physicians and other emergency medical

service (EMS) providers respond to both man-made and natural disasters. During disasters, we must have access to real-time data regarding all of the available health care resources in the affected region. However, unfortunately, emergency physicians do not always know where or how to find this essential information. In fact, ACEP surveyed its members in May 2018 and found that over a quarter of emergency physicians did not have complete access to real-time data when responding to a natural or man-made disaster or mass casualty incident.[1] This is not acceptable, and we strongly encourage the Administration to help improve providers' access to clinical data and information on available health care resources during these devastating events.

The lack of consistency regarding how data are displayed in EHRs also makes it hard for us as emergency physicians to search for what we need and find it in a timely manner. For example, some information can be stored in the EHR as a scanned image rather than as structured data, making it almost impossible at times to find the data we are looking for. Finally, we need to improve the way patient information is collected and entered into EHRs to better integrate it into the clinical workflow. A lot of the data we are forced to collect and screenings we are required to perform are not necessary and do not add clinical value. Also, as referenced above, we believe that a lot of the documentation and provider entry that we currently do is duplicative. We support the use of non-physician aids to put in orders and data and also encourage the use of scribes and dictation to reduce physician burden further. Going forward, we would like to see more advancements in technical innovations that would further automate the collection process of structured data (such as voice recognition technology and connected devices) and make it even easier for providers to enter usable information into EHRs.

Simplifying Reporting Program Requirements

The draft strategy discusses actions CMS has taken to reduce provider reporting burden under the Merit-based Incentive Payment System (MIPS). As referenced in the draft strategy, CMS finalized a new scoring methodology for the Promoting Interoperability category of MIPS. While ACEP appreciates CMS' effort to reduce complexity and burden, we are concerned that CMS has gone back to an "all or nothing" approach, which existed in the original Meaningful Use program. Under CMS' final policy, clinicians are required to report on all measures within each of the four objectives unless they claim an exclusion for a particular measure. Failure to report on one measure would make the clinician receive a score of zero for the entire category.

CMS did consider an alternative approach in the proposed rule that would have allowed scoring to occur at the objective instead of individual measure level. Under this alternative, if an objective includes two measures and clinicians did not report accurately on one measure (and failed to claim an exclusion) but did report accurately on the other, they would still be able to receive a Promoting Interoperability score. In ACEP's comments on the proposed rule, ACEP had supported this alternative. We believe that in order to realize the full potential of EHRs, requirements of the Promoting Interoperability category need to flexible in order to allow clinicians to incorporate available technology into their unique clinical workflows, to mitigate data access and functionality issues that might be unique to their practice and outside of the individual clinician's direct control, and to use EHRs in a manner that more directly responds to their patients' needs. Requiring that clinicians report every single measure or have to actively claim an exclusion creates an unfair burden and is antithetical to CMS' overall goal to streamline reporting requirements. Another possible change to the scoring methodology for the

[1] ACEP New Release, "Most Emergency Physicians Report Hospitals Lack Critical Medicines; Not "Fully Prepared" for Disasters, Mass Casualty Incidents," May 22, 2018, http://newsroom.acep.org/2018-05-22-Most-Emergency-Physicians-Report-Hospitals-Lack-Critical-Medicines-Not-Fully-Prepared-for-Disasters-Mass-Casualty-Incidents

Promoting Interoperability category of MIPS that would reduce complexity would be to assign point values for each measure proportionate to their overall value relative to the MIPS composite score. The total number of points in the Promoting Interoperability category would therefore be 25 (since the Promoting Interoperability category represents 25 percent of the total MIPS score), and clinicians would receive points for the measures that they choose to report. This approach would also eliminate the "all or nothing" scoring methodology that is currently in place and reward clinicians for reporting on those measures that are meaningful to them. Finally, ACEP supports a proposal put forth by the American Medical Association that would set a threshold of points that would dictate whether a clinician has "successfully" reported. Under this proposal, CMS would give full credit for the Promoting Interoperability category to any clinician with a score of over 50 points.

ACEP also believes that it is critical that clinicians not be limited by existing technology barriers and penalized for factors outside of their control. CMS must resolve fundamental cornerstones necessary for data exchange (e.g., patient matching, provider directories, standards, and privacy and security) and focus on increasing the functional interoperability between vendors and among vendors and registries to ensure this aspect of MIPS is achievable, meaningful, and not another unnecessary regulatory burden on clinicians. The Promoting Interoperability metrics themselves should focus only on what the individual clinician has direct influence over and not on the actions of other individuals—whether patients or other clinicians—or technology. Finally, it takes time for physicians to update their current systems with the latest technology. Therefore, CMS should consider providing six months or even a year for physicians to implement upgrades to 2015 certified EHR technology (CEHRT). CMS could also revisit the current certification structure more generally since it significantly stifles innovation for EHR developers and disincentivizes the development of user interfaces that more closely match how physicians actually practice.

There are other actions the Administration can take to reduce the reporting burden in MIPS. Specifically, one possibility CMS has looked into has been linking three of the performance categories -- Quality, Improvement Activities, and Promoting Interoperability – and establishing several sets of new multi-category measures that would allow MIPS eligible clinicians to report once for credit in all three performance categories. ACEP supports this concept of allowing clinicians to report on one set of measures and receive credit in multiple categories of MIPS, as it will help reduce the burden of reporting for physicians and also link elements of the program together into one cohesive function. Specifically, if the three performance categories of Quality, Improvement Activities, and Promoting Interoperability were linked together, the program could incentivize clinicians to use technological interventions to develop improvement initiatives and activities that improve patient care. We also believe that clinicians who use certified EHRs to participate in a clinician-led QCDR should be qualified as fully achieving all points for the Promoting Interoperability category. This would align with CMS's Patients Over Paperwork Initiative, as providing full Promoting Interoperability credit to these clinicians would significantly reduce unnecessary burden for providers.

Finally, specific to emergency physicians and other hospital-based clinicians, ACEP continues to be extremely concerned with how CMS defines "hospital-based" for the purposes of approving hardship exemptions for Promoting Interoperability category of MIPS. Clinicians who are deemed "hospital-based" as individuals are exempt from the Promoting Interoperability category of MIPS. However, if individual clinicians decide to report as a group, they would lose the exemption status if one of them does not meet the definition of "hospital-based." This "all or nothing rule" is unfair and penalizes hospital-based clinicians who work in multi-specialty groups. With respect to emergency medicine groups, there are also situations where a member of the group works in multiple settings. For example, an emergency physician might work two days a week at an urgent care center in order to provide additional staffing due to a colleague's maternity leave or due to a flu epidemic. The

whole group should not be penalized by this type of policy. The definition also does not align with how CMS treats groups for the purposes of the "facility-based scoring option." In order to qualify for that option as a group, only 75 percent of individuals in the group need to have met the criteria to be eligible for the option as individuals. Although CMS may argue that one possible solution is for clinicians who are deemed hospital-based to report as individuals, ACEP believes that for many of our members who have reported as part of a group in the past, especially those practicing in rural areas, reporting as individuals would be a significant administrative burden.

Qualified Clinical Data Registries

The draft strategy references the ongoing issue of specialists not being able to report on measures that are meaningful to them. Emergency physicians have experienced this problem in the past, and that is specifically why ACEP developed its QCDR, CEDR. Through CEDR, ACEP reduces burden for our members and makes MIPS reporting a meaningful experience for them. We strive to make reporting as integrated with our members' clinical work flow as possible and constantly work on improving their experiences and refining and updating our measures so that they find value in reporting them. We have found that if our members are able to report on measures that are truly clinically relevant, they become more engaged in the process of quality improvement. For each measure we develop, a Technical Expert Panel comprised of clinical, measurement, and informatics experts in the field of emergency medicine is assembled, and several criteria are considered when designing a measure, including each measure's impact on emergency medicine, as well as whether the measures are scientifically acceptable, actionable at the specified level of measurement, feasible, reliable, and valid. Through our work and partnership with CMS, we are proud to have been a certified QCDR for four years and have helped tens of thousands of emergency physicians participate successfully in MIPS.

While QCDRs have proven to be an excellent way to collect data and report quality measures, they are not even mentioned once in this draft strategy. Section 1848(q)(5)(B)(ii)(l) of the Social Security Act, as added by Section 101 of MACRA, requires HHS to encourage the use of QCDRs to report quality measures under MIPS. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). This is why we strongly believe, in line with this statutory requirement, that the final strategy should include a section reiterating HHS' commitment to QCDRs and describing how organizations, including medical associations such as ours, can continue to be incentivized to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes.

Public Health Reporting

Prescription drug monitoring programs (PDMPs)

In the draft strategy, HHS recommends that federal agencies, in partnership with states, should improve interoperability between health IT and prescription drug monitoring programs (PDMPs). ACEP believes that PDMPs play an essential role in identifying high-risk patients. We support effective and interoperable PDMPs that push prescription data to emergency physicians, rather than requiring them to sign into and pull the data separately from the PDMP. Currently, not all states have optimally functional PDMPs, resulting in highly variable usability and trustworthiness. Some states have not made commitments to make their PDMPs state-

of-the-art, and as a result they are cumbersome, may not contain real-time data, and the information can be unreliable. In addition, patients may cross state lines for care and not all states are part of InterConnect, which shares interstate information about dispensed prescriptions.

We think that ONC should consider adopting new EHR certification criteria that require EHRs to integrate PDMPs into their existing capabilities. Furthermore, CMS should require all PDMPs to be interoperable and to include certain standards, such as privacy and security protocols that protect patient-sensitive information.

42 CFR Part 2

ACEP agrees with HHS' recommendation to provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate the electronic exchange of health information for patient care. Emergency physicians see first-hand the toll that the misuse of drugs takes on individuals, families, and communities and it is vitally important that we have access to and share with other appropriate health care providers a patient's entire medical record to provide the optimal care. This information is necessary for safe, effective treatment and care coordination that addresses all of the patient's health needs. Failure to integrate treatments, services, and support information creates unnecessary risk for patients that can lead to contraindicated prescribing and problems related to patient non-compliance. Furthermore, obtaining multiple consents from a patient while providing emergency medical care can be challenging and time-consuming. For these reasons, it is critical that HHS provide more clarity on how providers, including emergency physicians, should be allowed to use substance use disorder health information for treatment, payment, and health care operations.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,

Vidor E. Friedman, MD, FACEP
ACEP President