American College of Physicians
Leading Internal Medicine, Improving Lives

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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
Via Email: Seema.Verma@cms.hhs.gov

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am writing as follow-up to our discussion at the White House listening session on EHR operability and interoperability, and to provide some tangible next steps to help guide the Agency's recently launched "Patients Over Paperwork" initiative. 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 would first like to reiterate the College's support for CMS' "Patients Over Paperwork" initiative. We appreciate that you have taken into consideration ACP's ongoing Patients Before Paperwork initiative as well as our previous recommendations on reducing administrative burden outlined in our major policy paper titled, "Putting Patients First by Reducing Administrative Tasks in Health Care," published last year in the *Annals of Internal Medicine*. When ACP initially launched the Patients Before Paperwork initiative in 2015, we began by surveying ACP membership to better understand the major administrative burdens they face on a regular basis and were not surprised to find that using their clunky electronic health records (EHRs) was at the top of their list. At the White House listening session, I had the opportunity to provide my own personal thoughts about how achieving EHR operability will reduce administrative and regulatory burden and ultimately enhance interoperability. Based on my previous remarks and long-standing ACP policy – the following is a list of ideas and immediate next steps CMS can take to improve operability of EHRs in order to reduce administrative and regulatory burden, enhance interoperability, and put high-value patient care at the forefront.

#1: Re-conceptualize and Re-score the Advancing Care Information (ACI) Component within the Merit-based Incentive Payment System (MIPS)

Both the CMS Patients Over Paperwork and ACP Patients Before Paperwork initiatives aim to streamline or eliminate administrative burden and put high-value patient care first. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) law's Quality Payment Program (QPP) is intended to better align the various Medicare reporting programs and reduce burden; which to a certain extent it does. However, the existing regulatory interpretation of how the ACI component needs to be scored is a continuing cause of EHR use burden, and thus distraction from what clinicians should be doing now, which is learning how best to use the EHR to improve care.

We appreciate that at the beginning of the Meaningful Use program – before there were any usable quality and cost measures – CMS had to rely on EHR functional use measures to support program integrity. That said our conditional support of EHR functional use measures was at best tepid, as we had concerns from the beginning that defining Meaningful Use with one set of use criteria – one-size-fits-all – would soon lead to EHRs feeling like they fit no one, and thus become a new source of burden. This concern was validated as early as 2012, when not only were EHRs no longer being mentioned as a potential solution to administrative burden; they were now identified by clinicians as their #1 source of burden and burn-out. And this sense of "one-size-fits none" EHR only became worse with the advent of Stage 2, and the promise/threat of Stage 3. What kept many EHR supporters optimistic thru these difficult years was the belief that Meaningful Use as a prescriptive program would soon end; and in its place would be some version of payment reform that would take into account quality and cost – and thus indirectly reward clinicians for how effectively they used their EHRs, instead of continuing to reward/punish EHR use from the vantage point of compliance.

That was indeed our hope until Acting Administrator Slavitt's announcement that Meaningful Use would end by December 31, 2016 – was clarified. Meaningful Use Stages 2 and 3 were not actually ending – they just changed their name to "Advancing Care Information" to become codified forever in the Merit-Based Incentive Payment System (MIPS) within the Medicare Quality Payment Program (QPP).

While we believe this essential continuance of Meaningful Use is a mistake, we understand that that this cannot be undone by CMS – as Advancing Care Information as a category of MIPS is included in the MACRA legislation. We also appreciate that the MACRA legislation mandates a linear scoring system for MIPS. We do believe that these legislative requirements still permit CMS to modify its regulations surrounding Advancing Care Information, such that adherence to this component of the program no longer adds EHR burden to clinicians, and no longer distracts clinicians from using EHRs to improve care for their patients.

The present composition of the various performance categories within the QPP MIPS, including the ACI performance category, are siloed and seem to be there to satisfy regulatory compliance rather than facilitate the enabling infrastructure of health IT to improve quality and value.

Ideally, the tasks performed under ACI would allow doctors, clinicians, and clinical informatics leaders to analyze and improve workflows and target the use of health information technology (health IT) for specific quality and value purposes.

The College has provided to CMS extensive feedback on how to improve the QPP, MIPS, and ACI specifically through regular rulemaking and public comment processes and I've highlighted below some of those recommendations as key next steps the Agency can take to reduce regulatory and administrative burden in Medicare:

> **ACP Recommendation: The College strongly recommends that CMS re-conceptualize and rescore the ACI category such that it more closely resembles the approach taken to the category of Improvement Activities**. Instead of base and performance categories, ACI should have base and elective categories – each with point values; and satisfaction of these categories would be (except where prohibited by legislation) by attestation.
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> **ACP Recommendation: The College urges CMS to modify the base score component of ACI and remove the threshold requirements of 1 or "yes" for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of health IT.** The proposed base measures, which are the same measures that physicians have already found to be cumbersome and inappropriate, do little to help clinicians move forward in using health IT to improve value of care. The College could support the base score requirement to report ACI measures – but only where the requirements do not contribute to poor usability, where the numerator and denominator of each measure were automatically calculated from the EHR, and where there were no base thresholds or performance requirements.
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> **ACP Recommendation: Change the performance score component of ACI to an elective category – where options that better fit certain specialties and scopes of practice are available for selection; and all (similar to the Improvement Activities component of MIPS) elective categories are satisfied by attestation.** Examples include adding data management and analysis capabilities, adding capabilities to share relevant clinical data among care team members, and adding new functions such as care plan management. Moreover, clinicians are facing a steep learning curve when it comes to implementing new health IT in their practices and should also have the option to select health IT education opportunities in addition to the base score component EHR-functional measures. CMS should then focus the review and improvement of ACI measures on the value of the measures and whether they assist practices in applying health IT to improve the quality and value of care and not focus on the performance levels of the measures.

The College believes that this type of reporting and subsequent data collection and analysis of ACI measures will lead to a better understanding of what works well in health IT processes and under what circumstances. A key component of the learning health and health care system will be data that help us determine how best to use health IT in care delivery. Data from practices that do not achieve all of the objectives and measures are just as valuable to a learning system

as data from those that are successful. ACI data will be most useful when they reflect actual workflow, not contrived attempts to achieve a performance threshold – even if the threshold value is only one. Learning is enhanced when reported data include naturally occurring variance and are not restricted to CMS' prescriptive definition of threshold achievement. This approach to ACI measures will avoid the prior pitfall of narrow and/or overly prescriptive measurement – as that has been the cause of compliance driven and/or duplicative clinical workflows, poor EHR usability, and distraction from the development of more usable and useful software. CMS and ONC could then collaborate on using these process data to learn – rather than to grade.

#2: Streamline and/or Eliminate Prior Authorization Requirements

Another major source of administrative burden for clinicians is the varying requirements and procedures for collecting data among both private and public payers – specifically for prior-authorization requests. Ideally, the need for prior authorization would decrease as the health care system continues to evolve to a more widespread value-based payment system, particularly for clinicians participating in risk-bearing alternative payment models. A great first step toward the ideal would be for CMS, private payers, and EHR vendors to accept the same clinical definitions for data elements and report formats, and work transparently with all necessary stakeholders, so that health IT could be programmed to generate and send the necessary prior-authorization criteria automatically. In other words, instead of a physician having to go through additional steps to provide information for the prior-authorization request (which could vary based on the patient's health plan), the required criteria should be automatically populated at the time of order entry – with little to no need for the physician to enter unnecessary data or perform a duplicative task outside of the clinical workflow. If prior authorization reporting requirements are standardized, and stakeholders agreed to use the same data and structure definitions, the burden of prior-authorization would be reduced dramatically and EHRs could become one of the key solutions to reducing administrative burden.

> **ACP Recommendation: CMS should collaborate with private payers, EHR vendors, physician organizations, and other necessary stakeholders in order to establish agreed upon clinical definitions for data elements and report formats so that the health IT could be programmed to generate and send data automatically. This agreement and process should be done in a transparent manner and include input from all necessary stakeholders.**

If this harmonization of standards and automation of prior-authorization across the industry was achieved, it would dramatically reduce practice costs for data interfaces; reduce the time clinicians and their staff spend completing additional forms; and reduce the time payers spend reviewing requests – freeing up time and resources to promote high-value patient care such as care management services.

#3: Simplify Evaluation and Management (E/M) Documentation Requirements

ACP is encouraged by the steps CMS has taken thus far to address the issues associated with E/M documentation requirements and greatly appreciates the recent update that now allows

teaching physicians to verify in the medical record any student documentation of components of E/M services rather than re-documenting the work. We applaud the Agency for removing this unnecessary and duplicative administrative task.

The College has additional recommendations for improvement that address some of the underlying issues with the current E/M documentation guidelines. As I am sure you are aware, the E/M documentation guidelines specify required contents of the medical record in excruciating — and often irrelevant — detail, often causing clinicians to over-document and making the medical record an ineffective source of communication. To address the elements specified in the guidelines, some clinicians are tempted to engage in extraneous clinical activity to justify using higher code levels. Moreover, the E/M codes themselves are a "one size fits all" set of codes used by all the specialties of medicine. They are premised on taking an extensive history from the patient and performing a physical examination. Caring for patients with multiple chronic illnesses does not require repeated, extensive physical exams or the taking of a traditional history once the information is initially captured. Examinations may be brief and focused and the history may revolve around functional issues. For cognitive specialties, the intensity of the visit requires making complex medical decisions for their patients. The E/M documentation guidelines as currently defined do not capture the work involved with this type of care in our modern era.

ACP provided detailed comments in our 2018 Physician Fee Schedule letter that are outlined below:

> **ACP Recommendation: Any revisions made to the E/M documentation guidelines should not result in a revaluation of the entire E/M code set.** This recommendation is an effort to reform the documentation guidelines to make them consistent with current medical practice and does not relate to the established values of the E/M services. The College is not proposing any changes to the E/M coding structure and seeks assurance that any changes to the E/M documentation requirements will not result in referral to the Relative Value Scale Update Committee (RUC) for review or an independent review of the code set by CMS.
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> **ACP Recommendation: Remove the auditing requirements associated with the history and physical exam elements of both the 1995 and 1997 E/M documentation guidelines.** Documentation of the history and physical exam should continue to be a key component of the patient visit but they should not be associated with the auditing requirements.
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> **ACP Recommendation: All relevant stakeholders, including medical specialty organizations, work with both the Current Procedural Terminology (CPT) Editorial Panel and CMS to create frameworks outlining general principles of care that are beneficial and appropriate for medical specialties in describing the varying approaches to patient care for the current levels of E/M codes.** These general principles of care would incorporate the existing medical decision making elements of the 1995 and 1997 E/M documentation guidelines in order to determine the level of service for the existing

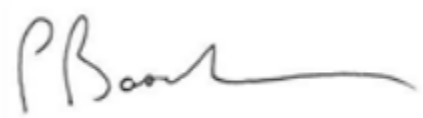
E/M codes, thus having clinical documentation tied to program integrity and auditing practices. The College looks forward to the opportunity to work with CMS on developing these frameworks and collaborating further on E/M documentation reform.

Once these frameworks and underlying principles are developed and agreed upon, EHR vendors would be required to build in an attestation based on the principles of care and the information captured within the EHR would be tracked to support the care delivered by the clinician relieving burdensome and duplicative documentation requirements.

Next Steps

The College is pleased to share these recommendations with CMS and hopes there is an opportunity in the near future to meet in-person and collaborate on our shared issues and concerns around administrative and regulatory burden. As the health care system continues to evolve from one based on volume to one based on value of services provided, it is important to address the issue of excessive administrative tasks and the serious adverse consequences it has on physicians and patient care. Thank you for your time and consideration. Please contact Shari M. Erickson, MPH, Vice President, Governmental Affairs and Medical Practice, by phone at 202-261-4551 or e-mail at serickson@acponline.org if you have questions or need additional information.

Sincerely,



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