PREMIER TRANSFORMING HEALTHCARE TOGETHER®

September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1693–P
Submitted electronically to: http://www.regulations.gov

Re: CMS–1693–P Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program.

Dear Administrator Verma:

On behalf of the Premier healthcare alliance serving approximately 4,000 leading hospitals and health systems, hundreds of thousands of clinicians and 165,000 other provider organizations, we appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule proposed rule. Premier healthcare alliance, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our owner hospitals and health systems that not only employ physicians, but also operate accountable care organizations. Premier runs one the largest population health collaboratives in the country, the Population Health Management Collaborative, in addition to an extensive Bundled Payment Collaborative. Below, the Premier healthcare alliance provides detailed comments with suggested modifications to the policies proposed by CMS.

REMOTE EVALUATION

For CY 2019, CMS aims to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology. First, CMS proposes to pay separately for a newly defined type of physicians' service furnished using communication technology. This service would be billable when a physician or other qualified healthcare professional has a brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit (GVCI1 Brief communication technology based service provided to an established patient, not

originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).Second, CMS proposes to create specific coding that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology (GRAS1 Remote evaluation of recorded video and/or images submitted by the patient, including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment). Finally, CMS proposes six codes that relate to interprofessional telephone/Internet assessment and management service provided by a consultative physician. **Premier supports CMS efforts to expand beneficiary access to services provided through communication technology.** We believe CMS should not be restrictive in the technologies allowed for the virtual check-in (GVCI1) to reflect the variety of technology that may be available to beneficiaries. Similarly, CMS should not be restrictive in the services or specialties that could be billed under the remote evaluation of pre-recorded patient information (GRAS1)**;** services should be made available to all patients, new and existing, as these services are intended to determine whether or not an in-person visit is warranted and not as a replacement. To ensure that beneficiaries are aware of the nature of the virtual check-in or review of information, providers should obtain consent, either verbally and noted in the medical record or electronically through manner which patients would send pre-recorded information.

Medicare Telehealth Services

CMS proposes to add two services to the Medicare telehealth services list. These services have been deemed by the agency to be sufficiently similar to services currently on the telehealth list. Premier continues to believe that telehealth services offer the ability to enhance consultations between patients and providers, enable remote monitoring, and generally improve communication and education between primary and specialty care providers particularly in rural and underserved areas. **The Premier health alliance supports CMS' proposed expansion of the services on the telehealth list.**

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS proposes to add new CPT code 994X7, which would correspond to 30 minutes or more of Chronic Care Management (CCM) furnished by a physician or other qualified healthcare professional, and to include it in the calculation of HCPCS code G0511. **Premier supports the proposed expansion of chronic care management provided by RHCs and FQHCs.** As with clinician payment, CMS proposes a separate payment for certain communication technology-based services including a separate payment for a "virtual check-in" and for remote evaluation of recorded video and/or images. CMS believes these visits could be particularly beneficial in rural areas where transportation is limited and the distance to these clinics is far as unnecessary in-person visits could potentially be avoided. **We agree that these services could provide for the**

expansion of services in rural and under-served areas where transportation options and access to specialties limit the ability of patients to receive appropriate care and should be reimbursed appropriately though separate payments. Premier supports separate payment for services provided through remote evaluation and believes these services should be made available through RHCs and FQHCs.

OFF-CAMPUS PROVIDER BASED DEPARTMENTS

The site neutral payments provision ("Section 603") of the Bipartisan Budget Act of 2015 precludes new off-campus provider departments (PBD) established after November 2, 2015 from being paid under the outpatient prospective payment system (OPPS) beginning January 1, 2017. In the CY 2017 interim final rule, CMS established site-specific rates under a special Medicare Physician Fee Schedule (PFS) that is a modified version of the OPPS. For the technical component for nonexcepted items and services, the site-specific rates were equal to 50 percent of the OPPS payment rate for CY 2017. Effective January 1, 2018, CMS changed the 50 percent adjuster to 40 percent of the OPPS rate. For CY 2019, CMS proposes the rate remain at 40 percent of the OPPS rate. The percent of the OPPS rate paid is known as the PFS relativity adjuster.

Premier continues to have concerns that the 40 percent PFS relativity adjuster is inadequate. As we have previously stated we believe that CMS should ensure that non-excepted PBDs are adequately reimbursed for the costs of care. PBDs often fill a void by providing the only source of primary and specialty care for low income populations in communities often incurring higher costs in treating their patients, whether because of the clinical complexity of their patients or the additional resources needed to provide interpreters and wrap-around services. Plus, these facilities support other critical community services despite inadequate reimbursement. These special circumstances result in higher costs in PBDs than the average freestanding physician office for a variety of reasons including a higher case mix.

Hospitals are now accountable for far more than simply the care provided within their four walls. They are responsible for overall patient experience, quality and costs through value-based purchasing, medical homes, bundled payments and accountable care organizations. Thus, health systems are seeking to provide care in more patient-centric, lower cost settings. Continuing the 40 percent PFS relativity adjuster will undermine hospitals' efforts to integrate and coordinate care between ambulatory, acute, and post-acute care sites. In the long run, higher outpatient payments compared to physician offices may be cost effective if the outpatient stays are in lieu of hospitalizations and part of more coordinated care. Excessively restrictive and complex payment policies undoubtedly will have downstream effects, mainly on patient access, and runs counter to delivery system reform. Moreover, reducing the number of outpatient clinics will only serve to put more of a burden on physician offices.

Hospital PBDs deserve to be paid a reasonable rate for the safe and high-quality care they furnish to beneficiaries. **CMS should increase the payment rate for non-excepted PBDs to adequately account for the higher costs associated with patients treated in PBDs. In addition, CMS should ensure that the payment amount for any non-excepted item or service is no less than what would be paid under the ambulatory surgical center (ASC) rate or the full non-facility PFS rate made to freestanding physician offices.**

EVALUATION AND MANAGEMENT VISITS

In response to stakeholder feedback that E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine, CMS is proposing several changes regarding home visits (CPT codes 99341 through 99350) and office/outpatient visit codes (CPT codes 99201 through 99215). Specifically, CMS proposes to:

- remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office
- allow practitioners to use either: 1) 1995 or 1997 guidelines; 2) medical decision making (MDM); or 3) time as a basis to determine the appropriate level of E/M visit allowing different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.

Relatedly, CMS is soliciting comments about deleting the Medicare Claims Processing Manual instruction that prohibits Medicare from paying for two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems that could not be provided during the same encounter. CMS notes that two physicians sharing the same Medicare enrollment specialty many not in fact practice the same subspecialty and that a beneficiary may appropriately need services from both physicians on a single day.

The Premier health alliance applauds CMS for determining approaches to reduce the E/M documentation burden and supports the proposed changes proposed above.

CMS is also proposing to pay a single rate for the level 2 through 5 E/M office visits. CMS notes that eliminating the distinction in payment between visit levels 2 through 5 will provide immediate documentation burden relief and eliminate the need for auditing based on the level of visit billed. CMS proposes to create two add-on HCPCS codes to capture additional resources consumed during certain specified office E/M services: GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services) to reflect additional resources inherent to primary care visits, GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain

management-centered care) and GPRO1 (when a prolonged E/M or psychotherapy services is 30 minutes beyond the usual service time). CMS says the proposed add-on codes would help to mitigate potential payment instability that could result from adoption of single payment rates that apply for E/M code levels 2 through 5. **Premier requests that CMS do not change the E/M visit payment at this time;** while we appreciate CMS' efforts to reduce documentation burden, this approach conflates documentation requirements with payment. The previously described proposed changes in documentation will significantly reduce clinician burden and should be finalized; however, those changes associated with office visit code family collapse should not. While the proposed payment approach is a step in the right direction, it may be too simplistic to replace the E/M office visit approach. **CMS should delay any payment changes in order to solicit additional stakeholder feedback on approaches for accounting for complexity of E/M services.**

PART B DRUGS

Effective January 1, 2019, CMS proposes to reduce Wholesale Acquisition Cost (WAC) based payments for Medicare Part B drugs made under section 1847A(c)(4) of the Social Security Act from the current WAC + 6% to WAC + 3%. CMS believes a reduction in WAC-based payments would help curb excessive spending by better aligning payments and drug acquisition costs, especially for drugs with high launch prices. The payment reduction is also expected to decrease beneficiary cost sharing.

Premier cautions CMS to carefully consider the unintended consequences of the proposed WAC-based payment reductions for Part B drugs. Such a reduction could incentivize manufacturers to inflate pricing as their drugs come to market so they are not at a competitive disadvantage to existing products that are reimbursed at ASP + 6%. Increased list prices by manufacturers would result in an increased cost for Medicare and beneficiaries. To help curb these potential practices and ensure a competitive marketplace, Premier recommends that CMS monitor for increases in list prices that are 3% or greater. Premier also recommends that CMS revisit this proposal in the near future after gaining some experience with the proposed reduction in WAC-based payments to determine if the reduction met its intended purpose of curbing excessive spending and make adjustments as necessary based upon the findings.

MEDICAID PROMOTING INTEROPERABILITY PROGRAM REQUIREMENTS

Renaming the Promoting Interoperability Performance Category

CMS is renaming the advancing care information" performance category to the Promoting Interoperability performance category. CMS is renaming the Medicare and Medicaid EHR

Incentive Programs as the Medicare and Medicaid Promoting Interoperability Programs. **Premier healthcare alliance supports CMS' efforts that focus on interoperability**.

Application of Scoring Methodology to the Medicaid Promoting Interoperability Program

CMS seeks public comment on whether to modify the objectives and measures for eligible professionals in the Medicaid Promoting Interoperability Program in order to encourage greater interoperability. Comments are also sought on the benefits of greater alignment with the Merit Based Incentive Payment System (MIPS). The **Premier healthcare alliance recommends that CMS align Medicare and Medicaid requirements to minimize MIPS eligible clinician burdens.**

MEDICARE SHARED SAVINGS PROGRAM

In continuing its Meaningful Measures initiative, CMS proposes to reduce the total number of measures in the Medicare Shared Savings Program (MSSP) measure set due to a high degree of redundancy and overlap with other measures.

Changes to CAHPS Measure Set

CMS proposes to begin scoring 2 summary survey measures (SSMs) that are already collected but are currently used only for information purposes:

- ACO-45, CAHPS: Courteous and Helpful Office Staff, and
- ACO-46: CAHPS: Care Coordination.

We support scoring these measures.

Changes to the Web Interface Measure Set

Measure Removal

CMS proposes to remove nine measures:

- ACO-35-Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- ACO-36-All-Cause Unplanned Admissions for Patients with Diabetes
- ACO-37-All-Cause Unplanned Admission for Patients with Heart Failure
- ACO-44-Use of Imaging Studies for Low Back Pain
- ACO-12 (NQF #0097) Medication Reconciliation Post-Discharge
- ACO-15 (NQF #0043) Pneumonia Vaccination Status for Older Adults
- ACO-16 (NQF #0421) Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up
- ACO-41 (NQF #0055) Diabetes: Eye Exam

- ACO-30 (NQF #0068) Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic

We agree with CMS that ACO-35, 36 37 are redundant with other measures already in the program. We have previously raised concern that ACO-44 has too small a denominator and is not reflective of true performance by MSSP ACOs. Accordingly, **Premier supports removing all the measures proposed for removal.**

New Measure

CMS proposes to remove *ACO-13 (NQF #0101) Falls: Screening for Future Fall Risk*, replacing it with *ACO-47 (NQF #0101) Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls*. The new measure is similar to the existing measure but also requires a plan of care, which includes consideration of vitamin D supplementation and balance, strength and gait training, for patients at risk for future falls. While we support removing the existing measure, we do not support inclusion of the new measure. Establishing a plan of care for patients at risk for falls is necessary care; however, this information cannot be captured electronically at this time. This measure will introduce burden as it requires medical record review. **In lieu of adding the revised falls measure, we encourage CMS to focus on developing patient reported outcome measures that can be captured electronically and assess the outcome of falls interventions from the patient's perspective.**

Potential Future Measures

CMS seeks comment on the possibility of adding the Skilled Nursing Facility Quality Reporting Program (SNFQRP) measure "Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facilities" to the MSSP quality measure set in future rulemaking. This measure differs from ACO-35 (proposed to be eliminated) because the SNFQRP measure looks only at unplanned, potentially preventable readmissions for Medicare FFS beneficiaries within 30 days of discharge to a lower level of care from a SNF, while ACO-35 assesses readmissions from a SNF, regardless of cause, that occur within 30 days following discharge from a hospital. As a result, the SNFQRP measure would have less overlap with ACO 8 (Risk-Standardized All Cause Readmission measure) than does ACO-35 (SNFRM). **The Premier health alliances believes that the SNFQRP measure would potentially add more value to the program measure set than ACO-35 as the SNFQRP measure is more targeted; however, we believe that CMS should test the measure in ACOs and consider risk adjusting the measure for socio-demographic factors prior to proposing for inclusion in the MSSP program.**

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Definition of a Merit-based Incentive Payment System (MIPS) Eligible Clinician

MACRA outlines the general definition of a MIPS eligible clinician for the first and second years of the MIPS program and allows the Secretary flexibility to specify additional clinician types as MIPS eligible clinicians in the third and subsequent years. The Secretary is leveraging this flexibility by proposing the addition of the following clinician types:

- Physical therapist,
- Occupational therapist,
- Clinical social worker
- Clinical psychologist, and
- A group that includes such clinicians.

Premier supports the expansion of clinician types eligible for participation in the MIPS program; however, we do not feel the program is encouraging enough clinicians to participate even though the barrier to entry is low.

Low-Volume Threshold Exclusion

For CY 2019 CMS is proposing to define the low-volume threshold as eligible clinicians or groups who meet at least one of the following three criteria during the MIPS determination period:

- Those who have allowed charges for covered professional services ≤ to $90,000;
- Those who provide covered professional services to ≤ 200 Part B-enrolled individuals; or
- Those who provide ≤ 200 or fewer covered professional services to Part B- enrolled individuals.

The Premier healthcare alliance contends that the new low-volume threshold criterion (as well as the existing two criteria) are set too generously, thereby barring too many eligible clinicians from MIPS participation. The Bipartisan Budget Act of 2018 provides the authority to maintain a low performance threshold for the first 5 performance years in MIPS. The intent is to allow clinicians to continue to acclimate to MIPS reporting without receiving a negative payment adjustment. We are concerned that summarily excluding a large number of clinicians (approximately 58 percent) will create a cohort of clinicians (and their patients) who are left behind as the value-based movement advances. Clinicians left behind would neither get performance feedback reports, nor would their performances be available on Physician Compare. **We believe that the still low overall MIPS performance threshold (composite score) is sufficient protection from negative adjustments for clinicians who may not have experience reporting in MIPS.** In this context**,** it is worth noting that very little of the MIPS program is in fact new for many clinicians, as, MIPS is a continuation of CMS programs that have been in

existence for years (i.e., the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier, and the Meaningful Use programs). While these programs were not without flaws, none of them had overall volume-based mechanisms to exclude providers from participation, so it is unclear why such exclusions are needed now for MIPS. The overarching intent of MACRA is to incent physicians to move from volume to value. When clinicians are exempt from MIPS there is little incentive to progress to broader cost management via participation in alternative payment models. **We urge CMS to raise the levels specified in the proposed rule and the existing low volume threshold criteria.**

Voluntary Opt-In

Beginning with the 2019 MIPS performance year, CMS proposes that if an eligible clinician or group meets or exceeds one or two, but not all, of the proposed low-volume threshold criteria, then these eligible individuals or groups may choose to opt-in to MIPS participation. CMS proposes that applicable eligible clinicians and groups would be required to make a definitive choice to opt-in by making an election via the QPP portal by logging into their accounts and selecting the option to opt-in (and receive a MIPS adjustment). Alternatively, those physicians or groups could choose to remain excluded but voluntarily report (and receive no adjustment) or to remain excluded and not to report at all to MIPS (and receive no adjustment). **As we have commented in the past, we appreciate that CMS is providing paths for clinicians who would otherwise be excluded to participate in MIPS by establishing an option to opt-in for the MIPS payment adjustment.**

Group Reporting

As discussed in the 2018 QPP final rule, stakeholders continue to request a group option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed and scored based on the subgroup performance. CMS is not proposing any changes but is considering the use of a subgroup identifier in the QPP program Year 4 through future rulemaking.

Premier has long advocated for the option to "split" TINs for the purpose of MIPS reporting. We continue to hear from our members, particularly those in large multi-specialty practices, that they would like to take advantage of group reporting but find it difficult to find six quality measures that are meaningful to the entire practice. CMS's current definition of group practice requires that groups select measures that may not be relevant to all of the clinicians in their group. **Premier supports development of a subgroup identifier as it will allow clinicians to split multispecialty groups and allow multiple TINs within a delivery system to report under a subgroup.**

We believe the existing MIPS policies should apply separately to each reporting subgroup; that is, the eligibility, performance, scoring and application of the MIPS adjustment policies remain

the same but are applied at the subgroup level. We do not believe performance should be aggregated across subgroups, similar to individual reporting, groups should have the ability to report as individuals, subgroups or groups. Similar to group reporting, we do not believe it would be necessary for subgroups to register as groups ahead of the reporting period for all reporting mechanisms except the Web Interface, as each submission could contain the proper information identifying which NPIs are included in the subgroup. CMS could track subgroups by creating submission fields identifying the number of subgroups within the TIN and the number of the individual submission (e.g. submission 2 of 10 subgroups) or creating TIN modifiers. **We encourage CMS to create a subgroup option that is available to all TINs for the CY 2019 reporting year.**

MIPS Performance Category Measures and Reporting

Collection Types, Submission Types, and Submitter Types

CMS noted concerns that the way it has described data submission by MIPS eligible clinicians, groups and third-party intermediaries does not precisely reflect the experience users have when submitting data. It has used the term "submission mechanisms" to refer not only to the mechanism by which data is submitted but also to certain types of measures and activities on which data is submitted, and to entities submitting the data.

To ensure clarity, CMS proposes to define the following terms:

- **Collection type** as a set of quality measures with comparable specifications and data completeness criteria including as applicable: electronic clinical quality measures (eCQMs); MIPS clinical quality measures (CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey measures; and administrative claims measures. The term MIPS CQMs would replace what were formerly referred to as registry measures.
- **Submitter type** as the MIPS eligible clinician, group, or third party intermediary acting on behalf of a MIPS eligible clinician or group, as applicable, that submits data on measures and activities under MIPS.
- **Submission type** as the mechanism by which the submitter type submits data to CMS, including, as applicable: direct, log in and upload, log in and attest, Medicare Part B claims and the CMS Web Interface. There is no submission type for cost data because the data is only submitted for payment purposes.

Premier supports the clarification of submission terms. We feel the definitions recognize the complexity of measure types and submission options and reduces the potential for confusion.

Quality Performance Category

Submission Criteria for Group Reporting CMS Web Interface Measures

CMS seeks comment on expanding the CMS Web Interface option to groups with 16 or more eligible clinicians. Preliminary analysis, however, indicates that expanding this option will likely result in many of these new groups not being able to fully satisfy measure case minimums on multiple measures. CMS notes it could require smaller groups, with 16-24 eligible clinicians, to report only on a subset of the CMS Web Interface measures, such as the preventive care measures. **Premier supports using the Web Interface as a mechanism for smaller groups to report; however, CMS should not combine benchmarks for large groups and ACOs with those for smaller groups.** While CMS does not establish separate benchmarks based on size in MIPS, we believe it will be necessary to do so to avoid disruption to the Web Interface benchmarks used in the Shared Savings Program.

Opioid High Priority Measure

Beginning with the 2019 performance period, CMS proposes to amend the definition of a high priority measure to include quality measures that relate to opioids. CMS proposes to define a high priority measure to mean an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure. Outcome measures would include intermediate-outcome and patient reported outcome (PRO) measures. **The Premier health alliance is supportive of opioid measures being classified as high priority; however, CMS should avoid the constant reclassification of high priority measures.** CMS should include in the definition of a high priority measure, measures that address an immediate public health concern. This would allow CMS to broadly recognize all topics that may be of immediate importance without having to constantly change the overarching definition. CMS could also use a sub-regulatory process to identify the topics that are immediate public health concerns.

Topped Out Measures

In the 2018 QPP final rule, CMS finalized a 4-year timeline to identify topped out measures, after which it may propose to remove the measure through future rulemaking. In the 4th year, if finalized through rulemaking, the measure would be removed. CMS proposes that once a measure has reached an extremely topped out status the agency may propose the measure for removal in the next rulemaking cycle, regardless of the measure's status in the measure lifecycle. For QCDR measures, CMS proposes excluding QCDR measures from the topped-out timeline. CMS states that when a QCDR measure reaches topped out status, as determined during the QCDR measure approval process, it may not be approved as a QCDR measure for the applicable performance period. **The Premier Healthcare Alliance supports the current policy for removal of topped out measures, but we do not support establishing a different policy for**

extremely topped out measures or QCDRs. The current topped out measure policy strikes a balance between maintaining sufficient measures for clinicians to report and removing measures that no longer are valuable to the program. We believe this policy should continue to apply to all measures, regardless of whether they were developed of use in a QCDR or are considered extremely topped out.

Removal of Quality Measures

The large number of process measures in the quality measure set are of concern to CMS. In the 2018 quality measure set, 102 of the 275 quality measures are process measures that CMS does not consider high priority. Because removing all non-high priority process measures would impact approximately 94 percent of the specialty measure sets, CMS believes it should incrementally remove these measures through notice and comment rulemaking. Beginning with the 2019 performance period, CMS proposes to implement an approach to remove process measures where prior to removal, consideration will be given but will not be limited, to:

- Whether the removal of the process measure impacts the number of measures available for a specific specialty;
- Whether the measure addresses a priority area highlighted in the Measure Development Plan;
- Whether the measure promotes positive outcomes in patients;
- Considerations and evaluation of the measure's performance data;
- Whether the measure is designated as high priority or not; and
- Whether the measure has reached a topped out status within the 98th to 100th percentile range, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made.

We do not support CMS' approach for incrementally removing process measures in the quality measure set. While we agree outcome measures are of higher value to the program, there is still value in process measures. Many process measures address topics where there is insufficient standardized data to assess an outcome. In lieu of routinely removing process measures from the program, CMS should focus on establishing data standards that will allow for more robust assessment of outcomes and de novo outcome measure development. **Moreover, CMS currently has approaches for removing low value measures from the program.** The topped-out measures policy and the annual review of measures included in the program by the Measures Applications Partnership (MAP) should remain the preferred approaches for identifying measures that should be proposed for removal from the program.

Categorizing Measures by Value

CMS discusses the implementation of a system where measures would be classified at a particular value (gold, silver, or bronze) and points are awarded based on the value of a measure.

For example, higher value measures that are considered "gold", could include outcome measures, composite measures, or measures that address agency priorities. **The Premier healthcare alliance opposes the categorization of measures by value as CMS already gives preference to measures in the form of bonus points.** We believe a new system would not provide any additional clarity for clinicians to identify measures that are of higher value in the program.

Cost Performance Category

Weighting in the Final Score

The Bipartisan Budget Act of 2018 provided flexibility in the weighting of the cost performance category in the final score. Instead of requiring this category to have a weight of 30 percent in Year 3 of the program (performance period 2019) the weight is required to be not less than 10 percent and not more than 30 percent for the third, fourth and fifth years of the QPP. For the 2021 MIPS payment year performance period 2019), CMS proposes that the cost performance category represent 15 percent of a MIPS eligible clinician's final score. CMS proposes to only modestly increase the weight of the cost performance category because it recognizes that cost measures are still relatively early in development and clinicians are not familiar with the measures. CMS considered maintaining the weight of the cost performance category at 10 percent for the 2021 MIPS payment year. CMS anticipates that it would increase the weight of the cost performance category by 5 percentage points each year until it reaches the required 30 percentweight for the 2024 MIPS payment year. **Premier urges CMS to maintain the weight assigned to the cost performance category at 10 percent for an additional year.** As CMS noted clinicians are still unfamiliar with the cost measures and are just receiving feedback on CY 2017 cost performance. Additionally, CMS is proposing to add new episode-based cost measures to the category for CY 2019 performance measurement. If CMS finalizes its proposal to increase the weight of the cost category, the new performance measures should contribute minimally (i.e. less than 50 percent) to the overall performance score.

Expansion of Performance Period

CMS is concerned that some clinicians and smaller groups may never see enough patients in a single year to meet the case minimum for a specific episode-based measure. CMS seeks comment on whether it should consider expanding the performance period for the cost measures form a single year to 2 or more years. CMS notes that expanding the performance period would increase the time between the measurement of the performance and the application of the MIPS payment adjustment. **We concur with CMS that a 2 year performance period may be better suited for some cost measures.** CMS should rely on experience from other quality performance programs (e.g. HVBP, HRRP) for determining when and how to apply a longer performance period. CMS should develop seek stakeholder feedback on developing a methodology and release a methodology report for public review and comment.

Promoting Interoperability (PI)

Renaming the Promoting Interoperability Performance Category

CMS is renaming the advancing care information" performance category to the Promoting Interoperability performance category. CMS is renaming the Medicare and Medicaid EHR Incentive Programs as the Medicare and Medicaid Promoting Interoperability Programs. **Premier healthcare alliance supports CMS' efforts that focus on interoperability**.

Application of Scoring Methodology to the Medicaid Promoting Interoperability Program

CMS seeks public comment on whether to modify the objectives and measures for eligible professionals in the Medicaid Promoting Interoperability Program in order to encourage greater interoperability. Comments are also sought on the benefits of greater alignment with the Merit Based Incentive Payment System (MIPS). The **Premier healthcare alliance recommends that CMS align Medicare and Medicaid requirements to minimize MIPS eligible clinician burdens.**

Certification Requirements Beginning in 2019

CMS will require MIPS eligible clinicians to use 2015 Edition certified EHR technology beginning with the 2019 MIPS performance period. **While Premier healthcare alliance supports the use of the 2015 Edition of CEHRT, we encourage CMS to employ flexibility in CEHRT requirements.** We are concerned that some MIPS eligible clinicians' migration to the 2015 Edition may be slowed due to vendor backlogs in updating their technology. **CMS should not penalize MIPS eligible clinicians who are prohibited by their vendor from using the 2015 Edition. Instead, CMS should consider developing an expedited hardship exemption application process for clinicians in this situation.**

MIPS Performance Period for the Promoting Interoperability performance category

CMS requests comments on the proposed performance period for the Promoting Interoperability performance category as a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year. **Premier supports this change.**

CMS proposes that the reporting period for EPs in the Medicaid Promoting Interoperability Program would be for a full calendar year in 2019 for EPs who demonstrated meaningful use in a prior year. This period also aligns with the MIPS performance period. **Premier supports this change.**

Submission Types and Processes

CMS clarifies that an individual MIPS eligible clinician may submit their MIPS data for the improvement activities or Promoting Interoperability performance categories using the direct, login and upload, or login and attest submission types. CMS also clarifies that groups may submit their MIPS data for the improvement activities or Promoting Interoperability performance categories using the direct, login and upload, or login and attest submission types. **Premier appreciates these clarifications.**

For the 2019 performance year, CMS proposes that the CMS Web Interface submission type would no longer be available for groups to submit data for the improvement activities and promoting interoperability performance categories. CMS recognizes the benefit of having data submitted by a third party intermediary and proposes to allow third party intermediaries to submit data using the CMS Web Interface on behalf of groups. **Premier supports this change.**

Scoring Methodology

CMS is proposing a new scoring methodology and moving away from the base, performance and bonus score methodology currently used. CMS wants to align the requirements of the Promoting Interoperability performance category with the requirements of the Medicare Promoting Interoperability Program for eligible hospitals and CAHs as they have finalized in the FY 2019 IPPS/LTCH PPS rule. This proposal would remove the availability of a bonus score for attesting to completing one or more specified improvement activities using CEHRT beginning with the 2019 performance period. If this policy is finalized, then CMS proposes to remove the criterion for selecting improvement activities entitled "Activities that may be considered for an advancing care information bonus". **Premier supports this change,**

CMS is proposing a new scoring methodology, beginning with the performance period in 2019, to include a combination of new measures, as well as the existing Promoting Interoperability performance category measures, broken into a smaller set of four objectives and scored based on performance. The scores for each of the individual measures would be added together to calculate the Promoting Interoperability performance category score of up to 100 possible points for each MIPS eligible clinician. In general, the Promoting Interoperability performance category score makes up 25 percent of the MIPS final score. If a MIPS eligible clinician fails to report on a required measure or claim an exclusion for a required measure if applicable, the clinician would receive a total score of zero for the Promoting Interoperability performance category. **Premier is supportive of CMS' new scoring methodology.**

Premier appreciates CMS' efforts to reduce burden and increase reporting flexibility for MIPS eligible clinicians. We are supportive of CMS' proposals to reduce the number of measures to be reported, allow exclusions and award bonus points. **We urge CMS to ensure that data**

standards exist for the proposed data elements within measures and have been widely adopted and are supported by vendors. We also recommend that CMS pilot test any new or revised proposed measures and confirm that CEHRT supports electronic measure collection and calculation before implementation of measures.

We urge CMS to allow MIPS eligible clinicians to obtain sufficient experience with the 2015 edition certified EHR and with the revised performance-based scoring methodology. Furthermore, MIPS eligible clinicians should be given the opportunity to review prospective measures and scoring in advance of their consideration by CMS.

Measures

e-Prescribing Objective Measures

The Premier healthcare alliance shares CMS' concerns about prescription drugs and opioid misuse and appreciates CMS questions related to state Prescription Drug Monitoring Programs (PDMPs). Premier has launched a series of efforts to address the opioid epidemic and make care safer. For example, hospitals in Premier's Hospital Improvement Innovation Network (HIIN), part of the CMS Partnership for Patients program, are participating in an initiative to measurably improve pain management among providers, clinicians and patients/families. To continue to improve opioid stewardship within the inpatient setting, Premier recently launched the national safer post-operative pain management pilot program with more than 30 hospitals to test and redesign new care delivery processes to better manage pain and the potential for drug addiction. We stand ready to share lessons learned and best practices, upon completion of this effort.

Premier urges CMS to convene stakeholders and subject matter experts (SMEs) to thoroughly and carefully address these complicated and patient care delivery questions before proceeding with the proposed opioid-related measures. More information is needed to confirm the feasibility and validity of the two new proposed measures (Query of PDMP and Verify Opioid Treatment Agreement) and the likelihood that they can be implemented electronically.

For the 2019 performance period, CMS proposes that the Query of PDMP and Verify Opioid Treatment Agreement measures would be optional. For the 2020 performance period, CMS is proposing to require the Query of PDMP and Verify Opioid Treatment Agreement measures but is also proposing an exclusion for any eligible clinician unable to report the measures because of varying State requirements, which do not allow e-prescribing of controlled substances.

As CMS notes, PDMP integration in CEHRT is not widespread and manual data entry and/or calculation may be required. Thus, **we believe that implementation of these measures will result in increased and unnecessary burden and related documentation requirements for MIPS eligible clinicians**. Additionally, given the wide variation of PDMPs, we urge CMS and ONC to identify and prioritize the need for revised or new CEHRT criteria as well as the

potential need for development, adoption and support for additional data, interoperability and transmission standards for these proposed new measures prior to their use.

Query of PDMP

This measure would assess the number of Schedule II opioid prescriptions for which CEHRT data are used to conduct a query of a PDMP for prescription drug history (except where prohibited and in accordance with applicable law). **We do not support this measure as proposed as it is not practical nor feasible**. It will result in increased and potentially duplicative reporting burdens for MIPS eligible clinicians.

We do not believe CMS should require clinicians to query the PDMP as state rules and regulations vary widely.[1] [2] [3] [4] [5] [6] **This requirement should remain at the state level to avoid creating duplicative or conflicting data collection or reporting requirements.** As previously stated, the proposed measure will require manual data collection activities and would therefore be extremely burdensome for MIPS eligible clinicians to systematically capture these data elements outside of an EHR. Before considering this measure, CMS should work with ONC to on standards development and implementation as well as on adoption and support of CEHRT criteria. **If CMS proceeds to implement this measure in the absence of adoption and support of data and interoperability standards and CEHRT criteria, reporting should be voluntary, optional and eligible for bonus points.**

Verify Opioid Treatment Agreement

This measure would assess the percentage of patients for whom a Schedule II opioid was prescribed during the EHR reporting period for whom the MIPS eligible clinician sought to identify a signed opioid treatment agreement and then incorporated any agreement found into CEHRT. **Premier believes that it is premature to require this measure as it is not feasible nor practical as proposed**. It is unclear how MIPS eligible clinicians will be able to locate and obtain treatment agreement(s). Moreover, evidence about the benefits and value of Opioid

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[1] Prescription Drug Monitoring Programs. Congressional Research Service. May 24, 2018. Congressional Research Service 7-5700 www.crs.gov R42593

[2] OPIOID TREATMENT AGREEMENTS. https://www.painnewsnetwork.org/stories/2017/3/21/little-evidence-that-pain-contracts-work)

[3] Treatment Agreements, Informed Consent, and the Role of State Medical Boards in Opioid Prescribing Summer McGee, PhD, CPH Ross D. Silverman, JD, MPH Pain Medicine, Volume 16, Issue 1, 1 January 2015, Pages 25–29, https://academic.oup.com/painmedicine/article/16/1/25/2460358#45360054

[4] OPIOID TREATMENT AGREEMENTS OR "CONTRACTS": PROCEED WITH CAUTION https://www.practicalbioethics.org/files/pain/pain-policy-issue-4-spring-2014.pdf

[5] Opioid Treatment Agreements: Helpful or Hurtful? https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp-rj.2016.110905

[6] Systematic Review: Treatment Agreements and Urine Drug Testing to Reduce Opioid Misuse in Patients With Chronic Pain

Article · Literature Review in Annals of internal medicine 152(11):712 · June 2010

https://www.researchgate.net/publication/271232805

Treatment Agreements is mixed.[6] [7] [8] [9] [10] **CMS should define/describe minimal requirements for an opioid treatment agreement; its minimal data elements and content/structure**. In the absence of CMS further defining an opioid treatment agreement, the proposed measure is vague and subject to misinterpretations and potentially useless while being extremely burdensome to MIPS eligible clinicians. **At a minimum EHR vendors must make any needed data exchange capability changes and engage in testing, demonstration and attestation**. CMS should solicit additional stakeholder and SME input about this proposed measure, such as potentially available and standardized data elements**. If CMS proceeds to implement this measure in the absence of adoption and support of data and interoperability standards and CEHRT criteria, reporting should be voluntary, optional and eligible for bonus points (beyond 2019 as proposed).** We note that in the final rule for hospitals and CAHs, this measure remains voluntary after 2019.

Rename Send a Summary of Care Measure

CMS proposes to rename this measure. Premier is generally supportive of this name change; however we believe that the measure's name is cumbersome and sounds too similar to the proposed new measure "Support Electronic Referral Loops by Receiving and Incorporating Health Information" and may result in unintended confusion. **We are supportive of CMS' proposal to allow MIPS eligible clinicians to use any document template within the Consolidated Clinical Document Architecture (CCDA) standard for purposes of the measures under this objective.**

Support Electronic Referral Loops by Receiving and Incorporating Health Information

CMS proposes to remove the Request/Accept Summary of Care Measure and the Clinical Information Reconciliation Measure based on stakeholder input and its own analysis. **Premier supports removing these measures.** CMS proposes to replace these two measures with the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure. **The Premier healthcare alliance supports this proposed measure in principle; however, this proposed measure does not address concerns present in the previous two measures**. We do not believe that this measure is technologically feasible without manual data entry or calculation, especially when patients are transferred or discharged to post-acute providers, who may not have implemented sufficient health information technologies. We have significant concerns due to the lack of adequate infrastructure for electronically exchanging summary of care documents with many MIPs eligible clinicians on the receiving end of transitions of care or referrals. **We do not believe it is reasonable to hold MIPs eligible clinicians responsible for other providers' inability to electronically receive and reconcile a document.**

Provider to Patient Exchange Objective Measures

CMS proposes to change the name of this objective to better emphasize patient engagement and access of health information through APIs. CMS is also proposing to change the name of the Provide Patient Access measure to Provide Patients Electronic Access to Their Health Information measure to better reflect the emphasis on patient engagement in their health care and patients 'electronic access of their health information through use of APIs. **We support renaming the objective and the measure.**

We are concerned that MIPS eligible clinicians will experience increased burdens until EHR they have gained experience working with their EHR vendor's APIs and the likely diverse array of patient-facing apps. We urge CMS to work with ONC to clarify to what extent patient-facing apps will need to meet criteria, including how an application will be registered. CMS and ONC should also address "app acceptance" (i.e., who will conduct apps review and vetting; how apps will be assessed for security vulnerabilities). Furthermore, CMS and ONC should clarify how activities undertaken by providers and MIPs eligible clinicians to secure their EHR platforms and other health IT systems to protect them from cyber-attacks and "bad actors", will be evaluated once ONC information blocking rules are promulgated and enforced. We urge CMS to further consider the wide range and increased security risks and vulnerabilities that MIPS eligible clinicians will face when connecting patient-facing apps to their EHRs via APIs. CMS should work closely with ONC, OIG, OCR, and FTC to align regulations and provide additional guidances about emerging security and privacy issues and considerations, especially those related to APIs and EHRs.

Removal of the Patient Specific Education Measure

CMS proposes to remove this measure because it has proven burdensome and detracts from program priorities. **We support removing this measure**

Removal of Patient Generated Health Data Measure

CMS proposes to remove this measure to reduce complexity. **We support removing this measure.**

Removal of Secure Messaging Measure

CMS believes that this measure does not align with the current program emphasis on interoperability, and notes the burden associated with tracking secure messages and the unintended consequences of creating new workflows designed for the measure rather than clinical or administrative effectiveness. **We support removing this measure.**

Removal of View, Download or Transmit Measure

CMS proposes to remove this measure based on the feedback it received from stakeholders regarding concerns about measures that require patient actions for successful provider attestation. **We support removing this measure.**

Public Health and Clinical Data Registry Reporting Objective Measures

CMS proposes to change the name of this objective to "Public Health and Clinical Data Registry Reporting." **We support renaming this objective.**

CMS states its intention to propose removal of this objective from the Promoting Interoperability Programs no later than the 2022 reporting year, and seeks comments on identifying other appropriate venues in which reporting to public health and clinical data registries could be encouraged. **Premier does not support the future removal of this objective as we believe it is imperative to continue to support and encourage public health reporting.** The importance of public health reporting is reflected in the 21st Century Cures Act as it explicitly includes requirements for EHRs to be able to send data to and receive data from registries.

The measures under the Public Health and Clinical Data Exchange objective are reported using "yes or no" responses and thus they are proposing to score those measures on a pass/fail basis in which the MIPS eligible clinician would receive the full 10 points for reporting two "yes" responses, or for submitting a "yes" for one measure and claiming an exclusion for another. If there are no "yes" responses and two exclusions are claimed, the 10 points would be redistributed to the Provide Patients Electronic Access to Their Health Information measure. A MIPS eligible clinician would receive zero points for reporting "no" responses for the measures in this objective if they do not submit a "yes" or claim an exclusion for at least two measures under this objective.

CMS is proposing that for this objective, the MIPS eligible clinician would be required to report on two measures of their choice from the following list of measures: Immunization Registry Reporting, Electronic Case Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Syndromic Surveillance Reporting. To account for the possibility that not all of the measures under the Public Health and Clinical Data Exchange objective may be applicable to all MIPS eligible clinicians, CMS is proposing to establish exclusions for these measures. **Premier supports these changes.** However, **Premier recommends that MIPS eligible clinicians be able to report additional measures within this objective for bonus points as a way to provide greater flexibility and experience using CEHRT and other health information technologies.** Integrating EHRs with other health information technology such as various types of registries is essential to MIPS eligible clinicians' efforts to provide high quality and efficient care. Advanced payment models increasingly require MIPS eligible clinicians' ability to access data from diverse data sources. Additionally, care delivery is enhanced when data from other sources (such as registries, surveillance reporting and quality applications) are available to and accessible from EHRs.

Potential New Measures

CMS seeks comments on a potential new measure, CMS Health Information Exchange Across the Care Continuum, in which a MIPS eligible clinician would send an electronic summary of care record, or receive and incorporate an electronic summary of care record, for transitions of care and referrals with a healthcare provider other than a MIPS eligible clinician. The measure would include healthcare providers in care settings including but not limited to long term care facilities and post-acute care providers such as SNF, home health, and behavioral health settings. **Premier agrees with this type of measure in theory; however we are concerned that these care settings and clinicians were not included in previous incentive programs and therefore may not have implemented EHRs.** Thus, electronic transfer of information between MIPS eligible clinicians and post-acute care providers as envisioned would be impractical and difficult to implement.

CMS also discusses an option to establish several sets of new multi-category measures that would cut across the three performance categories and allow MIPS eligible clinicians to report once for credit in all three performance categories. **We support this option and urge CMS to consider additional approaches that offer clinicians reporting flexibility while limiting reporting burdens.**

Premier supports CMS consideration of public health priority sets across all four MIPS performance categories. CMS believes that public health priority sets would allow clinicians to focus on activities and measures that fit within their workflow, address their patient population needs, and encourage increased participation in MIPS. CMS intends to develop the first few public health priority sets around opioids, blood pressure, diabetes, and general health (healthy habits). **Premier is supportive of CMS efforts to consider public health priority sets,** including specialty focused and condition specific measures. Before implementation, CMS needs to vet and test proposed approaches and specific measures. We urge CMS to consider public health priority sets that minimize data collection and reporting burden, such as by offering sets that emphasize use of common health IT functionalities and measures that can be readily collected, calculated and reported electronically. CMS could encourage or incentivize MIPS eligible clinicians to use public health priority sets by offering them as voluntary measures and eligible for bonus points.

The Premier healthcare alliance supports CMS' efforts to identify alternatives to the traditional program measures. Premier suggests that at a minimum, the following activities be recognized as advancing interoperability and spurring innovation: participation in local, state and/or national HIEs; participation in the Trusted Exchange Framework and Common Agreement (TEFCA); implementation of open APIs; implementation of clinical decision support (CDS) software; implementation of patient portals; and implementation of clinical surveillance and patient safety software and technologies. MIPS-eligible clinicians should be allowed to attest

to the adoption and use of these health IT functionalities and activities and obtain credit across performance categories. We offer the following examples:

- **Participation in TEFCA** should be considered in lieu of reporting on measures within the Health Information Exchange objective. However, we are not convinced that as proposed the TEFCA will help achieve nationwide interoperability as envisioned by the Interoperability Roadmap and the 21st Century Cures Act. However, once implemented, CMS should recognize TEFCA participation sand allow MIPS eligible clinicians to get credit under the Promoting Interoperability category in MIPS.
- **Maintaining an Open API** Allowing patients to access their health information through a preferred third party should be considered in lieu of reporting on Promoting Interoperability measures. Once implemented, APIs should allow MIPs eligible clinicians to get credit under the Promoting Interoperability category in MIPS.
- **Piloting Emerging Technology Standards** should allow MIPS eligible clinicians to get bonus points under the Public Health and Clinical Data Exchange objective for piloting emerging technology standards. CMS should establish criteria for emerging technology standards. For example, QCDRs collect information from multiple sources that can be used to develop prospective models that can predict decline in health. MIPS eligible clinicians using this type of technology to manage the health of populations should be recognized as an HIT activity that is awarded bonus points under PI. EHR vendors would need to implement emerging standards before expecting MIPS eligible clinicians to pilot them. We urge CMS and other agencies to accelerate and support development, implementation and adoption of appropriate transmission, syntactical and semantic standards.

Data and Interoperability Standards

We urge CMS and ONC to accelerate current standards development, testing, adoption, implementation and vendor support in order for interoperability to be fully realized. Such standards efforts are essential pre-requisites to achieving interoperability across the care continuum and healthcare settings. As CMS considers new Promoting Interoperability measures, we urge CMS to work with ONC and consider the availability data and interoperability standards as well as the readiness and feasibility of the industry's adopting available standards. Furthermore, the willingness and ability of vendors to support standards is another critical factor in achieving interoperability.

Reduce Provider Burdens

We are pleased that CMS continues to demonstrate its commitment to reduce unnecessary regulatory data collection and documentation and reporting burdens and costs for MIPS eligible clinicians. We strongly believe that HIT developers and EHRs must be required to demonstrate their ability to meet interoperability and health information technology requirements in advance

of establishing any expectations that MIPS eligible clinicians do so. Premier believes that in theory, it might be possible to reduce clinician reporting burden in the Promoting Interoperability category; however we believe that this would depend on the health IT activities that CMS recognizes and the related reporting requirements. We urge CMS to allow MIPS eligible clinicians to attest to diverse health IT activities as part of the Promoting Interoperability program, in lieu of traditional measures.

Measure Development and Adoption

Premier feels strongly that adding measures in the absence of evidence as to their value and feasibility of electronic capture, reporting and calculation is not practical nor beneficial and will result in additional burdens for MIPS eligible clinicians. Premier reiterates our recommendations that CMS should align measures and methodologies across programs and eliminate redundant reporting. Measures that require manual data collection and calculation should be eliminated. Premier recommends that CMS prioritize measures that are captured, collected and calculated electronically; measures that use data for which there are accepted and widely adopted standards; and measures that are supported by CEHRT.

CEHRT

The Premier health care alliance believes that CEHRT products should be recertified to a new version of CEHRT shortly after the new version is available; for example, within 12 to 18 months depending upon the complexity of the new CEHRT requirements. Ensuring CEHRT is up to date will enable MIPS eligible clinicians to meet reporting requirements. We caution that new CEHRT versions should be major revisions that address overarching health IT goals and impact storing, collecting and transferring data. Requiring vendors to regularly recertify to new CEHRT versions with minor changes will be a significant financial burden to MIPS eligible clinicians as vendors often pass on recertification costs to MIPS eligible clinicians. CMS and ONC should impose fines on vendors who attest to the update and then are not able to meet the requirements; MIPS eligible clinicians using vendors unable to meet new requirements should be allowed hardship exemptions from the reporting requirements**. Prior to implementing new or revised PI objectives/measures, CMS should ensure that the measures are field tested and are feasible in all applicable reporting methods.** This will help determine if the measure specifications are precise or open to interpretation. CMS should strengthen oversight of certified technologies' ability to calculate and validate data fidelity with regard to data, place, format and level of attribution**.** The CEHRT requirements should ensure that standardized data elements are implemented and supported to populate measures for all the federal reporting programs; ideally we believe it is essential that the certified technology be able to calculate the measures; at a minimum they should be able to seamlessly and reliably produce the required data elements. Certification should promote high fidelity data to reduce variability across EHRs, bi-directional exchange of information using Application Programming Interfaces (API) and timely data to enable interoperability.

Automatic Extreme and Uncontrollable Circumstances Policy

CMS proposes to codify the policy adopted for the transition year under which it will automatically reweight the performance categories for eligible clinicians who are affected by natural disasters or other extreme and uncontrollable circumstances affecting entire regions or locales beginning with the 2018 performance period/2020 payment year. Although the transition policy did not include the cost performance category because it then had a zero weight, this proposal would include all four performance categories. **As we have commented in the past, the Premier healthcare alliance believes applying the automatic exception will significantly reduce clinician burden. We support the adoption of this policy with the inclusion of the cost performance category.**

CMS continues to believe that an automatic policy is not needed for groups. **Premier feels strongly that CMS should apply the extreme and uncontrollable circumstances policy to groups in the same manner it does for individuals.** When clinicians opt for group reporting, all aspects of MIPS are conducted at a group level. If a portion of the TIN is affected by an extreme and uncontrollable circumstance, it may not be feasible for the remainder of the group to continue reporting. Similarly, for virtual groups the extreme and uncontrollable circumstance policy should apply to the entire virtual group if any TIN within the virtual group triggers the policy. For both groups and virtual groups, CMS could establish a process by which the unaffected clinicians in the group or virtual group can opt to submit as an individual.

MIPS Payment Adjustment

Establishing the Performance Threshold

For 2021 payment, CMS proposes a performance threshold of 30 points, which it says would represent a modest increase over the 15 points established for the 2020 payment year and would provide for the required gradual and incremental transition to the estimated 2024 performance threshold of 63.5 to 68.98 points. **We support a moderate increase to the performance threshold**, in accordance with the BBA of 2018. As we discussed earlier, **we encourage CMS to require more clinicians to participate in MIPS (i.e. lower the low-volume threshold criteria) while the overall performance threshold is low, allowing clinicians to gain experience in the program while potential negative payment effects are smaller.**

Public Reporting on Physician Compare

Benchmarks

CMS now proposes that benchmarks be built by incorporating historical data (rather than the most recent) into the ABC™ methodology, beginning with QPP Year 3 (2019 data for 2020

public reporting). Each measure would use data from a baseline period, defined as the 12-month calendar year that is two years prior to the performance period. For example, performance year 2019 benchmarks would be calculated using 2017 performance year data and published by January 1, 2019. CMS would substitute current performance year data for baseline period data in calculating the benchmark if the baseline period data were unavailable (e.g., 2019 performance data would be used to build benchmarks for CY 2019 performance period measures where historical benchmark period data were unavailable). The historical benchmarks would be published before the beginning of the relevant performance period, permitting clinicians to understand the performance required to receive a 5-star rating before data collection begins. **Premier has previously recommended that CMS use benchmarks from a prior performance period so that clinicians are able to understand how their measure score will translate into a 5-star rating, and we strongly support this proposal made by CMS.**

ADVANCED ALTERNATIVE PAYMENT MODEL (APM) INCENTIVE

Financial Risk Standard

Advanced APMs are required to bear more than nominal risk for monetary losses. CMS proposes to retain the 8 percent standard for QP Performance Periods 2021-2024; the standard applies to models that express risk in terms of revenue. The total expenditure-based nominal amount standard was set at 3 percent or greater beginning with 2017 without a specified date for expiration or increase, and no change is being proposed by CMS. CMS states that maintaining the current standards would continue a gradual implementation trajectory for the QPP, offer predictability to participants, and allow CMS to better assess the effects of the standards on the APM Entities. CMS seeks comment on whether it should consider raising the revenue-based nominal amount standard to 10 percent, and the expenditure-based nominal amount standard to 4 percent starting for QP Performance Periods in 2025 and subsequent years. **CMS should not consider increasing the financial risk standard for 2025 and beyond. It is our belief that the arbitrary risk standards finalized in the CY 2017 rule were set well above the true definition of "nominal" and should be lowered within in the CY 2018 rule for all provider types.** Moreover, CMS anticipates that recent proposed changes to the Medicare Shared Savings Program will cause a significant decrease in ACO participation. CMS should consider the level of adoption of Advanced APMs prior to changing the Advanced APM standard. MACRA is intended to incentivize providers to join APMs; however, in 2025 and beyond the QPP incentives, per statute, will change and become less favorable when compared to the MIPS track. Clinicians reaching APM Qualifying Participant (QP) status would receive only 0.7 percent fee schedule payment update. Although non-QP clinicians would receive a smaller (0.25 percent) update, they would have the potential to earn a + 9 percent MIPS adjustment. So, for example, clinicians participating in MIPS APMs, who constitute a high-performing group, would be better served by not transitioning to Advanced APMs. With reduced incentives to join Advanced APMs, requiring a higher financial risk standard for those APMs will further deter clinicians

from joining Advanced APMs. **We recommend that CMS maintain the current financial risk standard for 2025 and beyond.**

Other Payer Advanced APM Multi-Year Determinations

Stakeholders have told CMS that the extensive information submission currently required annually for Other Payer Advanced APM to renew their determinations as "Advanced" is burdensome and that other payers often execute multi-year contracts. CMS now proposes to retain annual submission for both the Payer-Initiated and Eligible Clinician-Imitated processes but with modifications that would begin with performance year 2020. Under the proposal, once CMS initially determines that a payment arrangement meets Other Payer Advanced APM criteria, requesters (payers, APM Entities, and eligible clinicians) submitting multi-year arrangements would be required to submit annually only information about changes related to the Other Payer Advanced APM criteria. If no such payment arrangement changes are made, CMS would extend the initial Advanced APM determination for each successive year for up to five years or until the end date of the arrangement, whichever occurs earlier. As part of the information submission for the initial determination, the requester would be required to certify that revised information would be provided to CMS about any material change. CMS believes that these modifications would align Medicare's processes with those of other payers, reflect more accurately the typical timeline on which payers revise APM arrangements, and encourage the development of stable, multi-year, Other Payer Advanced APMs. **We applaud CMS for its responsiveness to stakeholder concerns and support a multi-year determination as it will significantly reduce clinician burden.**

REQUEST FOR INFORMATION ON PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE

CMS is interested in feedback from stakeholders on how it could use the Conditions of Participation (CoPs), Conditions of Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care (LTC) Facilities to advance electronic exchange of health information in support of care transitions between hospitals and community providers.

Premier strongly supports the development and implementation of an efficient and effective infrastructure for health information exchange across the care continuum. Hospitals, health systems and clinicians continue to make significant investments in certified electronic health records (EHRs). We appreciate CMS' desire to address interoperability and data exchange but **we are strongly opposed to using the CoPs/CfCs/RfPs to advance interoperability or electronic data exchange.** CMS should not implement interoperability requirements in the CoPs/CfCs/RfPs as they are not the appropriate vehicle(s) to encourage interoperability or electronic data exchange given the significant consequences to providers (noncompliance could result in the inability of providers and clinicians to participate in the Medicare and Medicaid programs). Furthermore, there are inconsistent definitions of interoperability and wide variation

in measures/metrics for interoperability. CMS should address these discrepancies as part of its ongoing Promoting Interoperability efforts.

Furthermore, existing CMS and ONC efforts to achieve interoperability are evolving "works in progress", still in their early stages of development and implementation and thus immature. CoPs/CfCs/RfPs are typically restrictive in acceptable approaches for meeting the condition, thereby limiting providers' flexibility to test and implement novel approaches. **Including requirements for interoperability and electronic data exchange in the CoPs/CfCs/RfPs/ would create an extreme penalty (i.e. potential exclusion from Medicare) for aspects that are currently penalized through other CMS requirements and reporting programs (i.e., the Promoting Interoperability Program, QPP, MIPS).** Furthermore, requiring providers to meet interoperability requirements via the CoPs/CfCs/RfPs, while also reporting Promoting Interoperability measures and participating in other contemplated Federal efforts, such as the Trusted Exchange Framework and Common Agreement (TECFA) would be unnecessarily and extremely burdensome and duplicative.

CMS invited stakeholder feedback on questions regarding possible new or revised requirements for interoperability and electronic exchange of health information. In the chart below (*CMS Proposal for interoperability-related CoPs/CfCs/RfP)*, we provide brief responses to CMS' specific questions.

CMS also invited comments about how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers and to identify fundamental barriers to interoperability and health information exchange. Following the chart, Premier provides detailed suggestions about attaining interoperability goals and addressing barriers. **We believe that it is premature for CMS to consider imposing COPs/CfCs/RfPs until the barriers and challenges to exchange have been fully addressed.**

CMS Proposal for interoperability-related CoPs/CfCs/RfP	
CMS Question	**Premier Response**
If CMS were to propose a new CoP/ CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?	As Premier explains in greater detail below, **we are opposed to adding any requirement(s) for electronic exchange of medically necessary information within the CoP/CfC/RfP standard**(s). Furthermore, CMS provides no clear definitions of several terms (i.e., "medically necessary", "materially discourage" and "information blocking exceptions"; definitions are essential to responding to CMS' questions. Furthermore, there are no details about ONC's planned implementation of information blocking rulemaking (as required by Section 4004 in the 21st Century Cures Act). Thus, **any efforts by CMS to address information blocking via CoP/CfC/RfP are inappropriate and premature.** Adding interoperability requirements to the CoP/CfC/RfP would result in significant additional and duplicative administrative and reporting burdens. In particular, incorporating data into workflow and ensuring that data are available and accessible to clinicians and their patients in a usable and

	understandable manner is critical to achieving interoperability. CMS should focus its efforts on applying current policy levers; refining requirements for CEHRT; accelerating standards development and implementation; and allowing providers and clinicians greater flexibility to receive credit for using health information technologies beyond legacy EHR platforms.
Should CMS propose new CoPs/ CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient or resident access as well as interoperability?	**Premier is opposed to any use of the CoPs/ CfCs/RfPs to ensure a patient's or resident's (or his or her caregiver's) or representative's right and ability to electronically access his or her health information without undue burden**. Providers who qualify for the Promoting Interoperability program will have implemented patient portals and/or APIs that provide the level of access required by the certification criteria. Thus new CoPs/CfCs/RfP are not necessary. The current use of portals and the expected implementation of open, public and published APIs will likely satisfy the requirement regarding patient or resident access to health data. However, in order to fully realize the benefit of APIs, CMS and ONC must focus attention on requiring EHR vendors to publish and consistently implement and support open (non-proprietary) APIs to make health information more accessible to providers and their patients. Moreover, CMS must provide clear definitions of terms such as "electronically access his or her health information without undue burden"; "health information" and "undue burden" as used within their question(s).
Are new or revised CMS CoPs/CfCs/ RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, the implementing regulations related to the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–91), and implementation of relevant policies in the 21st Century Cures Act?	**Premier is opposed to any use of the CoPs/CfCs/RfPs for interoperability and electronic exchange of health information**. CMS needs to allow sufficient time and experience with existing (and planned) CMS Medicare and Medicaid policies and ONC activities (i.e., 2015 CEHRT criteria for interoperability) and regulations related to the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–91), and implementation of relevant policies in the 21st Century Cures Act).
What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?	As Premier explains in greater detail below, **we are opposed to any use of the CoPs/CfCs/RfPs as a mechanism to address interoperability and electronic exchange of health information**. Rather than expanding the CoPs/CfCs/RfPs, CMS should provide greater flexibility and offer alternative approaches and mechanisms to give credit to providers and clinicians for their use of diverse health information technology activities, beyond legacy EHR platforms.
Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer	As Premier explains in greater detail below, **we are opposed to any use of the CoPs/CfCs/RfPs as a mechanism to require hospitals and other participating providers ensure interoperability and electronic exchange of health information**. Rather than implement yet another set of additional requirements, CMS should allow providers to gain experience with current and

of health information as well as overall patient/resident care and safety?	planned policies intended to help achieve interoperability (i.e., TEFCA and use of 2015 CEHRT) before considering other policy levers. CMS must address the multiple barriers described in our letter which, if ignored, will continue to impede nationwide interoperability.
Under new or revised CoPs/CfCs/ RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/ resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?	**Premier is opposed to any use of the CoPs/ CfCs/RfPs as a mechanism to require hospitals and other participating providers ensure interoperability and electronic exchange of health information.** However, CMS must allow/permit the use of non-electronic forms of sharing medically necessary information when the receiving provider, supplier, or patient/resident cannot receive the information electronically.
Are there any other operational or legal considerations (for example, implementing regulations related to the HIPAA privacy and security standards), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?	**Premier is opposed to any use of the CoPs/ CfCs/RfPs as a mechanism to require hospitals and other participating providers ensure interoperability and electronic exchange of health information**. Following this chart, we provide a more detailed description of recommendations for achieving interoperability and a discussion about existing barriers and challenges faced by hospitals, clinicians and other providers and suppliers in meeting existing CMS and ONC program requirements for interoperability and health information exchange.
What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP, including CEHRT hardship or small practices, be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?	**Premier is opposed to any use of the CoPs/CfCs/RfPs as a mechanism to require hospitals and other participating providers ensure interoperability and electronic exchange of health information.** CMS should continue to allow exceptions under the QPP, including those related to CEHRT hardship or small practices.

In the discussions below, we identify fundamental barriers to interoperability and health information exchange and offer comments and recommendations about how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers.

Premier Recommendations on Achieving Interoperability

Premier has identified a number of ways that CMS (working with other agencies) can help promote interoperability. In the discussion below, we address a number of issues and offer specific recommendations:

- Use and Adapt Existing Policy Levers
- Implement 21st Century Cures Provisions
- Update and Maintain Certified EHRs
- Information Blocking
- Timelines and Reporting Requirements
- Offer Providers Maximum Flexibility
- Security

Use and Adapt Existing Policy Levers

Providers and clinicians continue to make progress exchanging and sharing information.[7] [8] However, the current and future policy landscape for interoperability and EHRs remains unclear. CMS and ONC should allow providers time to gain experience with the various existing policy, technical and programmatic updates expected over the next few years before considering other avenues to promote interoperability. CMS must align and use existing mechanisms and policy levers (such as the Promoting Interoperability Programs, MIPS, QPP, CEHRT, and HIPAA) to help achieve interoperability. CMS needs to work with ONC and other federal agencies (such as NIST) to implement relevant 21st Century Cures Act (Cures) provisions, including information blocking, APIs, the EHR Reporting Program, the TEFCA and the U.S. Core Data for Interoperability (USCDI). We anticipate that the required use of 2015 CEHRT and APIs will help improve interoperability and believe that forthcoming API, interoperability and CEHRT rules by ONC will also help address CMS' goal to promote interoperability and reduce provider burdens. **Providers and clinicians must be given sufficient time to implement and adapt to these changes and CMS and ONC must evaluate their impact before considering other mechanisms or processes to attain interoperability.**

Furthermore, existing policy levers unfairly target and penalize providers (i.e., hospitals, health systems and clinicians). EHR vendors are currently not required to demonstrate interoperability, usability or their platforms' conformance to standards. Providers and clinicians are unable to incorporate electronic information received into their EHR due to the limitations of the EHR itself (i.e., incongruent implementation of standards, misaligned standards, semantics, and inconsistent implementation of standards specifications)--all hindering data flow and impeding useable and understandable data across EHRs and other health information technologies and systems. CMS and ONC must address improving the functions and capabilities of EHRs, including: information exchange across EHRs; accurately identifying (matching) patients across EHRs; and ensuring that data are easily incorporated into workflow. The ability to transmit data into and obtain from EHRs is critical and EHRs must be required to demonstrate this capability as part of CEHRT testing (as is required under Cures Section 4005 for clinical registries).CMS

[7] Sharing Health Information for Treatment. https://www.aha.org/guidesreports/2018-03-01-sharing-healthinformation-treatment
[8] Expanding Electronic Patient Engagement. https://www.aha.org/guidesreports/2018-03-01-expanding-electronicpatient-engagement

and ONC must recognize these types of impediments, barriers and challenges to interoperability and address them directly.

EHR adoption among hospitals, clinicians and providers who were not eligible to receive incentives to implement certified health information technology, including post-acute care, long-term care, rehabilitation, and psychiatric hospitals, lags significantly. **CMS should focus on approaches to incentivize the use of health IT in order to drive interoperability for providers and clinicians not previously eligible for incentives (i.e., community health providers, clinical subspecialties, post-acute care and long-term care providers)**.[9] The absence of incentives for these settings and providers has stalled adoption of health IT; without adoption in all settings interoperability along the continuum is not feasible.

Implement 21st Century Cures Provisions

Implementation of several Cures provisions is long overdue. CMS must work with ONC and other agencies to align and harmonize administrative and reporting programs, such as CMS' Promoting Interoperability Program, ONC's CEHRT program, and TEFCA in order to reduce provider burden, eliminate redundant and unnecessary reporting, and further interoperability. Premier expects that existing and contemplated polices and rules (such as those related to TEFCA and implementation of several provisions in the 21st Century Cures Act) may contribute to progress on exchange of health information and interoperability. However, final proposals about TEFCA and USCDI are pending, the timeline for their releases remains uncertain, and their impact cannot be assessed until rules are promulgated, implemented and enforced.

CMS and ONC must provide more clear and detailed information about their processes and timelines to implement Cures provisions and how they will harmonize and align Cures provisions with the Promoting Interoperability Programs. ONC's forthcoming proposed rules (i.e., APIs, registries, certification and information blocking) will likely impact the envisioned Promoting Interoperability Program. However, lacking detailed information about CMS and ONC actions, stakeholders are unable to provide more responsive comments to this RFI. Premier expects to have the opportunity to comment further once ONC issues proposed rulemaking required under Cures and once CMS articulates how those rules will impact its programs, including the Promoting Interoperability Program. CMS and ONC must assure that future versions of CEHRT support and are aligned and harmonized with CMS' programmatic and reporting requirements.

Regarding APIs, it is essential that ONC and CMS operationalize the goal of 21st Century Cures mandating that health information "can be accessed, exchanged, and used *without special effort* through the use of application programming interfaces (APIs)." ONC and CMS must clarify that such certified EHRs must support an industry-recognized standard and the APIs must be open, public and published.

[9] Interoperability 2017 https://klasresearch.com/images/pages/events/Cornerstone_Interop_White_Paper_2017.pdf

Providers must have reliable, robust and transparent information about EHRs' usability, functions and level of interoperability. To help providers select and measure performance of EHR products, Cures (Section 4002. Transparent Reporting on Usability, Security, and Functionality) requires the establishment of an Electronic Health Record (EHR) Reporting Program that includes product features and capabilities (such as a product's security, usability and interoperability).[10] Premier urges CMS and ONC to accelerate the implementation of this Cures' provision and also include information about EHR vendors' material limitations and types of costs associated with its API functionality and app integration capabilities, in order to assure an open marketplace, ongoing innovation and a robust app ecosystem.

Cures (Section 4005 Clinical Registries) requires EHRs to be technically capable of transmitting to, receiving and accepting data from registries as a condition of certification in accordance with standards recognized by ONC. This includes clinician-led data registries that are certified to be capable of receiving, accepting and transmitting data to certified EHR technology. It is essential that CMS work with ONC to ensure that this provision be implemented as soon as possible.

Update and Maintain Certified EHRs

Furthermore, ONC must continue to address CEHRT usability, interoperability, functionality and capabilities and ensure that CEHRT and EHR testing processes are aligned with CMS' requirements. ONC's efforts and activities should include the following:

- Ensure that providers, such as health systems, hospitals and clinicians (in addition to patients) can access EHR data using any application of their choice that is conformant with/configured to meet the technical specifications of the ONC-recognized API standard within the CEHRT
- Ensure that providers' (health systems, hospitals and clinicians) can readily extract data from and insert data into their EHRs (ability for EHRs to send and receive data)
- Minimize the need for manual data collection, abstraction, calculation and/or reconciliation within Federal reporting and administrative programs (i.e., Promoting interoperability; MIPS; QPP)
- Require CEHRT to use standardized data elements, definitions, and formats so that data and information can be more easily documented, collected, accessed, extracted and used
- Require EHR vendors to implement EHR platforms and systems using consistent, replicable, scalable and supported data and interoperability standards
- Assure that CEHRT requirements easily support and are harmonized with CMS administrative and reporting requirements
- Address CEHRT usability, interoperability and ability to support clinical workflow
- Harmonize CEHRT with the CCDS and the future USCDI

[10] ONC Report to Congress April 2016. Report on the Feasibility of Mechanisms to Assist Providers in Comparing and Selecting Certified EHR Technology Products https://www.healthit.gov/sites/default/files/macraehrpct_final_4-2016.pdf

Information Blocking

There are numerous challenges and barriers related to effective data sharing, especially with different EHRs.[11] CMS must clarify terms and definitions relating to interoperability and information blocking and ONC must issue proposed rules about information blocking. However, CMS **should not use the CoPs/CfCs/RfPs to address real or perceived instances of information blocking.** Current EHRs do not allow for the easy use, exchange or sharing of data. Legacy EHR vendors are restricting data flow and are preventing competition and limiting innovation by implementing proprietary and/or restrictive vetting processes that govern if and how a third-party product or application can integrate with the EHR.[12] [13] [14] [15]

CMS efforts to address provider information blocking must be coordinated with ONC efforts and Cures' requirements to address EHR vendor information blocking. Providers and clinicians depend on their EHR vendors to implement timely and appropriate software and system upgrades and changes to accommodate new ONC and CMS requirements and should not be penalized for EHR vendors' business practices or reluctance to implement new CEHRT requirements.

Furthermore, the Office of Civil Rights (OCR) should provide additional guidance clarifying and ensuring that providers have flexibility to address any potential security vulnerabilities and threats from consumer-facing apps. ONC, CMS, FTC and OIG should align and clarify their rules, regulations and guidances to ensure that all stakeholders understand their responsibilities in the context of the evolving app ecosystem. Again, we strongly urge CMS, FTC, OIG, and ONC to consider how policy related to security, APIs and information blocking will consider issues involving the use of APIs. Furthermore, we believe that CMS and ONC continue to underestimate the potential security risks and vulnerabilities and application "vetting and registration" burdens that CMS expects to providers to assume as they fulfill CMS and ONC requirements to implement consumer-facing APIs.[16]

As noted in Cures, ONC must implement updated maintenance of certification requirements and rules about information blocking, and APIs. We urge CMS to work with ONC to ensure that CMS' Promoting Interoperability measures and requirement are fully aligned with CEHRT. Cures require EHR vendors to:

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[11] Castillo et al. Vendor of choice and the effectiveness of policies to promote health information Exchange BMC Health Services Research (2018) 18:405 https://doi.org/10.1186/s12913-018-3230-7
[12] https://code.cerner.com/apps
[13] https://open.epic.com/
[14] https://www.healthcareitleaders.com/blog/4-takeaways-from-the-epic-app-orchard-developer-conference/
[15] http://www.modernhealthcare.com/article/20170222/NEWS/170229974
[16] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16766.pdf

- Attest, as a condition and maintenance of certification that it: (a) did not engage in information blocking, (b) provided assurances that it will not engage in information blocking or take any action that may inhibit the exchange, access and use of electronic health information unless for a legitimate purpose specified by the Secretary of HHS, and (c) did not prohibit or restrict communication regarding the usability, interoperability or security of HIT;
- Demonstrate that it does not prohibit or restrict information regarding: (a) users' experiences when using HIT, (b) its business practices related to exchanging electronic health information, and (c) the manner in which a user has used the technology;
- Attest that it published application program interfaces (APIs) and allows health information from such APIs to be accessible, exchanged and used without special effort through the use of APIs or successor technologies or standards, including providing access to all data elements of a patient's EHR to the extent permissible under applicable privacy laws; and
- Attest that it has successfully tested the technology for interoperability in the setting in which it will be marketed.

We expect that promulgation and enforcement of fair and equitable information blocking rules can go a long way to helping address vendors' practices that might interfere with, prevent, and materially discourage the access, exchange, or use of electronic health information. [17] As previously noted, OCR should provide additional guidance allowing providers to assess and verify the security of patient-facing apps without risk that such practices would be considered information blocking.

Timelines and Reporting Requirements

Providers face extreme and unnecessary burdens due to frequently changing CEHRT and CMS administrative and reporting requirements. Providers need a clear and defined level of predictability so that they can respond approximately to proposed changes and anticipate their implementation. Changes to the Promoting Interoperability and CEHRT programs typically result in significant time for EHR vendors to develop and launch software revisions/updates and then providers require sufficient time to budget and plan for and then operationalize EHR changes. Having additional certainty will bring stability as providers continue pushing forward on data exchange and pursue solutions that require interoperability. CMS must recognize the true financial impact and administrative burden incurred by hospitals and health systems in implementing CMS (and other agencies') administrative and reporting requirements. We believe CMS has significantly underestimated these burdens in the impact analyses.

Offer Providers Maximum Flexibility

[17] ONC Report to Congress April 2015. Report on Information Blocking.
https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf

CMS notes that a focus on interoperability and simplification will help reduce healthcare provider burden while allowing clinicians and providers increased flexibility to pursue innovative health information technology activities and applications that improve care delivery and increase the likelihood of achieving nationwide interoperability. Thus, CMS is exploring the creation of a set of priority health IT activities that would serve as alternatives to the traditional EHR Incentive Program measures.

We support CMS efforts to introduce additional flexibility to allow providers a wider range of options to "get credit" for various health information technology activities. Providers' use of patient portals and other health information technologies (such as portals and open APIs) should fully satisfy CMS' requirements that providers ensure a patient's or resident's (or caregiver/representative) right and ability to electronically access his or her health information as well as to meet overall interoperability requirements. Future recognition of certain health IT activities, like participation in the TECFA as an alternatives to traditional program measures provide hospitals, health systems, clinicians and other providers greater flexibility and promote innovative uses of health IT. Other use(s) of health information technology beyond CEHRT (such as other systems, applications and modules) should also qualify providers' successfully fulfilling CMS promoting interoperability requirements. Providers should be able to report and receive credit for health information technology activities that are most appropriate to their setting, patient population, and clinical practice improvement goals.

Premier urges CMS to focus attention on allowing providers' maximum flexibility to obtain credit for their innovative use of health information technologies. As the 2015 CEHRT requires providers to implement open APIs that allow patients' access to their health information, we strongly believe that providers should be able get "credit" for interoperability when using these APIs. Providers should also get credit for their use of health information technologies and applications beyond certified EHRs as providers need solutions outside their EHRs to support value-based care and population health management programs and initiatives.[18] [19]

CMS must allow providers' flexibility when information cannot be sent or received electronically. Exceptions need to be available for providers, such as smaller urban and/or rural providers; community-based providers; and small practices and other providers for whom incentives have not been available to encourage their adoption and implementation of electronic health records. Furthermore, data must be able to flow across the continuum of care, including to and from post-acute care and long term care providers. Many subspecialties, long term, post-acute care and skilled nursing facilities often do not have EHRs, or at least do not have CEHRT. Connecting providers along the care continuum is essential to achieving nationwide interoperability; CMS should focus efforts on incentivizing and encouraging adoption of CEHRT in these and other settings.

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[18] Sage Growth Partners (SGP). Are EHRs up to the task? March 2018 http://sage growth.com/index.php/2018/03/ehrs-task-sage-growth-partners-report/

[19] Stalled Progress on the Path to Value-Based Care. http://quanumsolutions.questdiagnostics.com/2018survey

Security

CMS emphasizes patient engagement in their healthcare and patients' electronic access of their health information through use of APIs. The CMS Blue Button 2.0 initiative enables Medicare beneficiaries to connect their Medicare claims data applications, services, and research programs they trust (https://bluebutton.cms.gov/). CMS has developed app criteria that need to be met and verified by the CMS Blue Button API team, including how an application is registered with CMS. Yet, there are no guidances or "rules of the road" regarding compliance with CEHRT 2015 (for open APIs) nor for Promoting Interoperability measures that require the use of APIs to share data with apps of the patients 'choosing.

We urge CMS to work with ONC and clarify what processes and criteria will be developed for patient-facing apps required under this Promoting Interoperability measure. CMS and ONC must also address "app acceptance" (i.e., who will conduct apps review and vetting; how apps will be assessed for potential security vulnerabilities). Furthermore, CMS and ONC must clarify how activities undertaken by providers and MIPs eligible clinicians to secure their EHR platforms and other health IT systems to protect them from cyber-attacks, will be evaluated once the ONC rules about information blocking are promulgated and enforced. We believe that CMS' responses to commenters in the final IPPS rule[20] about APIs, consumer-facing apps, information blocking and potential security risks, fails to acknowledge the increasing cybersecurity risks and vulnerabilities faced by the entire health system.[21] [22] [23] Existing applicable laws and guidances appear to be woefully inadequate.

Barriers and Challenges to Interoperability and Recommendations to Address Them

There are several major barriers and challenges impeding interoperability that should be addressed by CMS, ONC and other Federal agencies prior to any further consideration of adding interoperability requirements to the CoPs/CfCs/RfPs, including the following:

- Non-competitive EHR marketplace
- Limited EHR functions
- Heightened need for open, non-competitive APIs
- Value-based care and advanced payment models require data beyond EHRs

Premier urges CMS and ONC to consider these ongoing challenges and barriers when developing future policies and expectations of providers. Following our discussions of barriers

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20 https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16766.pdf

21 https://www.csoonline.com/article/3260191/security/healthcare-experiences-twice-the-number-of-cyber-attacks-as-other-industries.html

22 https://www.phe.gov/preparedness/planning/CyberTF/Pages/default.aspx

23 https://www.phe.gov/Preparedness/planning/CyberTF/Documents/report2017.pdf

and challenges, Premier offers several recommendations and action items for how CMS and ONC can address these barriers.

Non-competitive EHR marketplace

A major challenge contributing to this ongoing shortfall in achieving nationwide interoperability is the increasingly non-competitive health information technology marketplace dominated by a relatively small number of legacy EHR vendors[24] [25] along with ongoing clinicians' dissatisfaction with existing EHRs.[26] [27] As the EHR market has matured, the number of EHR vendors has narrowed significantly. In March of 2015, 10 EHR vendors accounted for about 90 percent of the hospital EHR market, based on meaningful use attestation data from CMS.[28] According to the ONC's Health IT Dashboard, three companies had 60 percent of the market share combined. A report from KLAS found that two companies each held about one-quarter of the acute care hospital EHR market share in 2016.[29] [30] A Black Book survey of 3,000 hospital EHR users finds that two-thirds of hospitals don't use patient information from outside their own EHRs because it's not available within their workflows.[31] Furthermore, an average hospital has 16 disparate EMR vendors in use at affiliated practices and 75 percent of the hospitals are dealing with 10+ disparate outpatient vendors.[32] A recent CMS report [33] discusses ACO challenges associated with health IT, multiple EHRs, interoperability, data analytics and the impact of health IT on health care cost, utilization, and quality. While providers and clinicians have experience sharing and exchanging health information with other providers and with patients, there are obstacles out of the providers' control that hinder or prevent achieving interoperability.[34]

Stimulus funding (government supported $30B) flowed to EHR vendors, while the penalties and burdens for not implementing certified technology and achieving interoperability remains with providers, creating provider dependence on EHR vendors. EHR vendors are not yet accountable for demonstrating and assuring interoperability, while providers remain dependent on their vendors. Legacy EHR platforms impede and/or do not allow real time data flow to/from EHRs

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[24] https://www.definitivehc.com/hubfs/infographics/electronic-health-systems-ehr.pdf?t=1528465230285
[25] https://www.kaloramainformation.com/Content/Blog/2017/04/28/The-State-of-the-EMR-Market-in-2017
[26] https://www.healthcare-informatics.com/article/ehr/cmios-parse-complexities-md-dissatisfaction-ehrs
[27] Mark W. Friedberg, Peggy G. Chen, Kristin R. Van Busum, Frances Aunon, Chau Pham, John P. Caloyeras, Soeren Mattke, Emma Pitchforth, Denise D. Quigley, Robert H. Brook, F. Jay Crosson, Michael Tutty Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. https://www.rand.org/pubs/research_reports/RR439.html
[28] https://www.beckershospitalreview.com/healthcare-information-technology/50-things-to-know-about-the-ehr-market-s-top-vendors.html
[29] https://medcitynews.com/2017/05/epic-cerner-ehr-market-share/
[30] https://www.beckershospitalreview.com/healthcare-information-technology/epic-cerner-hold-50-of-hospital-ehr-market-share-8-things-to-know.html
[31] https://www.prnewswire.com/news-releases/epic-systems-and-meditech-rise-atop-black-book-2018-survey-of-inpatient-ehr-client-satisfaction-joining-cerner-and-cpsi-300633557.html
[32] https://www.healthcareitnews.com/news/why-ehr-data-interoperability-such-mess-3-charts
[33] https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf
[34] Castillo et al. Vendor of choice and the effectiveness of policies to promote health information Exchange BMC Health Services Research (2018) 18:405 https://doi.org/10.1186/s12913-018-3230-7

and clinical workflow. Furthermore, EHR vendors retain practical control over clinical data, limiting third party app development and innovation and provider data access.

EHR market dominance and related "power" position makes application (app) developers and providers subject to EHR vendor business practices and generally unwilling/unable to challenge EHR vendors. Providers and clinicians continue to incur ongoing high costs for EHR platforms and systems interfaces, data, applications and implementations and application integration while facing unrelenting administrative and reporting burdens and excessive EHR costs. Provider dependence on EHR vendors results in a lack of data flow, higher costs, inflexible products, challenging implementations and diminished innovation. Furthermore, in spite of multiple private- and public-sector initiatives to improve the interoperability landscape, the GAO has identified several ongoing challenges to achieving nationwide interoperability nationwide.[35] There still is much work to be done to assure that providers and clinicians can easily use, share and exchange information and efficiently add functionality and capabilities to their EHR platforms (such as via APIs).

Limited EHR Functionality

Providers need robust, scalable, and interoperable health IT systems and EHRs to deliver high quality and cost effective care and to improve clinical decision making and deliver improved outcomes. Hospitals and health systems report that barriers to the sharing and effective use of received patient information continue to exist at many levels, from timing of receipt and formatting of the information to technical issues in the exchange transaction or the EHR itself. [36] Interoperability will enable systems to move beyond simply recording data in EHRs toward integrating and combining data to streamline analytics on supply chain, financial, public and population health and clinical care for evidence-based decision-making. Value-based care (VBC), advanced payment models and population health management (PHM) approaches focus on prevention and care coordination functions often lacking in legacy EHRs.[37] [38]

Without connectivity across the care continuum, data collection remains fragmented and does not provide the total picture necessary for healthcare providers to deliver informed, coordinated care. Further, the movement towards value-based care and alternative payment models has created an even greater imperative for health information exchange and interoperability. Advanced payment models such as ACOs and bundled payments involve participation by multiple providers, suppliers and sometimes payers who are at risk for coordinating the care of patients, requiring the ability to access and aggregate information from different EHRs, systems, applications and across multiple facilities and care settings. Current legacy EHRs' limit clinical

[35] United States Government Accountability Office ELECTRONIC HEALTH RECORDS Nonfederal Efforts to Help Achieve Health Information Interoperability. September 2015 https://www.gao.gov/assets/680/672585.pdf
[36] Sharing Health Information for Treatment. https://www.aha.org/system/files/2018-03/sharing-health-information.pdf
[37] https://assets.sourcemedia.com/a4/a3/98a6529b44e9ab724f84f89b4d2b/philips-wellcentive-realizing-the-value-in-value-based-care-wp-final.2.pdf
[38] https://klasresearch.com/report/population-health-management-2017-part-2/1230

decision making and quality patient care as they thwart innovation, collaboration and free exchange of information critical in delivering informed, safe and coordinated care.

EHRs are increasingly limited in their ability to meet providers' growing needs for core value-based care functions. Providers need to be able to add enhanced capabilities and functionality (i.e., risk stratification, case management, referral management, care coordination, decision support, data analytics, clinical surveillance, registries, enterprise analytics, and patient engagement) to their EHRs and not be restricted or hampered by their EHR vendors' practices when doing so. Increasingly, EHRs cannot provide access to complete patient data at the point of care, a limitation that continues to hinder providers' confidence that all the information necessary to make informed decisions is available when and how it's needed.

Open, Publicly Available and Non-competitive APIs

One of the potential solutions to address the problem of limited EHR functionality, is open APIs. CMS and ONC have focused on enabling consumer and patient access to health information. Blue Button 2.0 provides patients access to their Medicare claims data and the 2015 CEHRT requires for EHRs to implement APIs for consumer-facing apps. However, such efforts are inadequate to achieve full scale interoperability.

We are concerned that serious challenges and barriers prevent providers from accessing and using EHR data. APIs have the potential to allow access to EHRs and health data; however EHR vendor implementation of APIs is inconsistent. Furthermore, providers and app developers face significant costs when trying to add functionality into or "on top of" EHRs. Thus, EHR vendor business practices are stifling innovation. Premier believes that CEHRT, via APIs must support health care providers' access to health information in order to help achieve widespread interoperability,

CMS has implemented the Blue Button 2.0 as a way to promote interoperability by allowing beneficiaries to access their claims data via an API and to share their data with applications of their choosing. To further promote interoperability and data access, we urge CMS to develop and implement a similar (access to claims data) functionality for providers by allowing providers to access and download their patients' Medicare claims via an API.

Premier believes that providers and clinicians need their EHR vendors to provide public, open and fully accessible APIs to make health information more accessible to providers so that providers can connect applications to their EHRs and enhance their functionality. As previously noted, ONC's 2015 CEHRT requires EHRs to allow patients to access their clinical data via APIs. ONC should implement similar CEHRT requirements for APIs for provider facing apps. Allowing data to be accessible through fully open, standardized and consistently implemented APIs will spur novel approaches to data integration and use, leading to a more open, innovative and competitive health IT market. Providers and other stakeholders must be able to connect and

exchange data and information with other current, new and emerging health IT systems, modules and applications, medical devices and sensors across the care continuum, care settings, facilities and delivery systems/networks, without unfair and unnecessary restrictions placed on then by EHR vendors. EHR vendors (business practices) should not require providers to obtain permission to connect applications of the providers' or clinicians' choosing to the EHR platform.

Providers need maximum flexibility under federal reporting programs (such as quality, payment and public health) to obtain credit for their innovative use of diverse health information technologies and activities. As the 2015 CEHRT requires providers to implement open APIs that allow patients' access to their health information, providers should be given "credit" for interoperability when using these APIs. Providers need access to data and technology solutions outside their EHRs to support value-based care and population health management programs and other initiatives [39] [40] and should be able to get credit for their use of health information technologies and applications beyond certified EHRs.

There is an increasing demand for a growing range of health IT products, services, and applications, beyond the capabilities and functions of legacy EHR platforms. While CEHRT 2015 requires the use of APIs to give patients access to their health information through mobile applications of their choice, much work remains for ONC to develop certification requirements and implement specific CEHRT criteria for APIs. Additionally, ONC should ensure that providers can easily access their EHR data via APIs.

Suggested priority actions for CMS and ONC include the following:

- Allow providers to connect apps of their choosing to EHRs via open, public and publishable APIs, without obtaining the EHR vendors' permission
- Harmonize definitions and requirements for health information technology (i.e., base EHR; CEHRT; USCDI, TEFCA; health IT; modules/functions) across federal administrative, reporting, quality and payment programs
- Recognize, designate, support and enforce consistent, scalable and fair EHR use of an industry standard for the required open APIs (i.e., HL 7 FHIR; SMART on FHIR; or successor standard)
- Accelerate efforts to ensure that APIs are standardized, openly published, and consistently implemented to ensure provider data access and use at the point of care and within clinical workflow
- Develop and implement a transparent, open national testing and vetting/approval infrastructure and processes for APIs and apps to encourage innovation, assure consistent interoperability specifications and implement fair and equitable app dissemination
- Assure that an app once "approved" is able to be reused in all certified EHR platforms

[39] Sage Growth Partners (SGP). Are EHRs up to the task? March 2018 http://sage growth.com/index.php/2018/03/ehrs-task-sage-growth-partners-report/
[40] Stalled Progress on the Path to Value-Based Care. http://quanumsolutions.questdiagnostics.com/2018survey

- Clarify and clearly define "without special effort"
- Extend and accelerate open API standards for: bulk data export; clinical decision support; and bi-directional data flow (read-write into and out of EHRs)
- Align and harmonize TEFCA and USDI with current end future CEHRT and Promoting Interoperability requirements

Significant challenges exist regarding standards: variability in EHR vendor implementation of standards; insufficiencies in interoperability standards; lack of attention to semantic interoperability; and inconsistent use of terminologies and formats. Information that is electronically exchanged from one provider to another must adhere to the same standards, and these standards must be implemented uniformly, in order for the information to be understandable and usable, thereby enabling interoperability.[41]

Additional recommendations and actions items regarding CEHRT include the following:

- Provide transparent and publicly accessible information about their products and services, including capabilities, functions, security, APIs, fees and costs, usability, and interoperability
- Demonstrate/attest that they allow third party applications, modules, systems and products to seamlessly and securely connect to and integrate with their EHRs
- Attest that they do/will not unintentionally or deliberately restrict providers from integrating with or connect to their EHRs to applications, services, and modules of the providers' choosing
- Support workflow processes and incorporate user-centered design principles
- Demonstrate interoperability (i.e., ability to send and received structured and unstructured data) and use standardized data elements, definitions, and formats so that data and information can be more easily documented, collected, accessed, extracted and used in accordance with CEHRT criteria
- Facilitate providers' need to easily extract data from and insert data into their EHRs (bi-directional data flow)
- Ensure availability and accessibility of health data (including structured and unstructured clinical data) for an individual patient, panel of patients, or a population of patients

CMS and ONC must require EHR vendors to publish public and open APIs so that providers can seamlessly integrate third party applications and health information technologies and applications with EHRs. EHRs must demonstrate their ability to meet Promoting Interoperability measures and CEHRT criteria and related requirements in advance of establishing any expectations that providers do so. Furthermore, CMS must work with ONC to clarify the glide path from the current common core clinical data (CCDS) and the 2015 CEHRT to future

[41] ELECTRONIC HEALTH RECORDS Nonfederal Efforts to Help Achieve Health Information Interoperability Report to Congressional Requesters. United States Government Accountability Office. September 2015 https://www.gao.gov/assets/680/672585.pdf

versions of CEHRT and the proposed USCDI. ONC and CMS must clearly delineate how future versions of CEHRT, CCDS and/or the USCDI will be recognized and implemented within Federal administrative, reporting, quality and payment programs. ONC and CMS must assure that any future requirements will not unfairly burden providers. CMS, ONC and other federal agency reporting and administrative requirements must be aligned and harmonized.

Summary

Value-based care (VBC) and advanced APMs require data-driven, technology-enabled data exchange, data sharing and interoperability across the continuum of care -- beyond EHRs. The ecosystem is moving toward population health management, accountable care organization (ACO) development, APMs and other initiatives that demand more robust data and analytics capabilities and diverse health IT tools and functions.

The movement towards VBC and the advent of APMs has created an even greater imperative for health information interoperability. Advanced payment models involve participation by multiple providers, suppliers and sometimes payers who are at risk for coordinating the care of patients, requiring the ability to access and aggregate information across disparate sites of care, facilities, organizations and different health IT systems and EHRs.

Actionable insights drawn from clinical, financial, and socioeconomic data are critical for succeeding with population health management and value-based care. Identifying, intervening and managing patient care requires a combination of risk stratification, case management, referral management, care coordination, data analytics, and patient engagement functions and capabilities that require systems and applications in addition to EHR platforms.

Data analytics are key to success under value-based payments and APMs. Successful quality improvement by healthcare providers requires effective use of clinical, financial and other data. Access to data will inform risk modeling, help providers identify patients who may benefit from targeted interventions, enable more effective patient engagement initiatives, design and evaluate quality improvement initiatives, identify and close clinical care gaps and implement workflow efficiencies to control costs.

Premier supports efforts to transform healthcare through the power of data and health information technology (IT). As discussed above, there are many obstacles, barriers and challenges—many outside of the control of hospitals, health systems and clinicians,—that impede and prevent their ability to seamlessly exchange information. It is essential that CMS and ONC first address and resolve ongoing interoperability barriers and challenges so that providers can improve care delivery, patient safety and performance, and drive operational efficiencies.

Premier continues to advocate for, develop and implement innovative solutions to achieve open data access across health IT systems and technologies to support the industry's VBC transition

across the care continuum. The Premier healthcare alliance appreciates that CMS is seeking comments about interoperability and patient access; however, **we stress that the CoPs/CfCs/RfPs are neither appropriate nor effective levers to achieve interoperability, spur innovation, or ensure provider and patient access to data.**

PRICE TRANSPARENCY: IMPROVING BENEFICIARY ACCESS TO PROVIDER AND SUPPLIER CHARGE INFORMATION

The Affordable Care Act established the Public Health Service Act, which requires each hospital operating within the United States to make public a list of its standard charges for items and services including for diagnosis-related groups according to guidelines established by the Secretary. In the FY 2018 IPPS rule, CMS required hospitals to make available a list of their current standard charges via the internet in a machine-readable format and to update this information at least annually. CMS discussed continued challenges for patients due to insufficient price transparency, including that surprise billing and chargemaster data is not helpful for patients, and seeks comment on improving price information for consumers.

Premier supports price transparency and believes that CMS should work to help consumers understand price information; however, providing standard charges will not address CMS' concerns with price transparency. Gross level costs are not useful to patients in that it does not consider contractual allowances, plan coinsurance structures, charity care policies and mission driven expenses such as teaching programs, etc. Moreover, it is difficult to identify the actual costs associated of care because the components such as staffing, overhead, and materials costs are accounted for inconsistently across the healthcare system. Moreover, there is a lack of price transparency for underlying materials costs. Better price transparency on underlying material costs could be a first step in providing more consistent information. In order to make progress in being able to better identify costs, which would assist in estimating expected payment by the uninsured, under-insured and those patients with health savings accounts, Premier recommends chargemaster reform.

The current Medicare cost reporting system precludes providers from fundamentally overhauling charge masters. **CMMI should establish a multi-payer voluntary demonstration that allows providers to rebase and reset relative costs within their charge masters.** Private payers would need to develop a hold harmless to ensure provider payments do not drop significantly by reducing charges. CMS would need to waive cost reporting rules and make adjustments to the payment systems that rely on cost to charge ratios for rate setting. Recognizing this would require significant effort, CMS should provide technical assistance as well as funds to providers during a transition period when participants would need to submit cost reports under the old system and a new system. Demonstration participants would provide ongoing feedback to CMS regarding the initiative.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit these comments on the CY 2019 Medicare Physician Fee Schedule proposed rule. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, senior director, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior vice president, Public Affairs
Premier healthcare alliance