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Don Rucker, MD  
National Coordinator for Health Information Technology  
Office of the National Coordinator for Health Information Technology  
Mary E. Switzer Building  
330 C Street SW  
Washington, DC 20201

*Submitted electronically*

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

Dear National Coordinator Rucker:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the US Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology's (ONC) Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health Information Technology (IT) and Electronic Health Records (EHRs). The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

APTA appreciates that ONC has developed a strategy for reducing regulatory and administrative burden relating to the use of health IT and EHRs. The draft strategy outlines 3 primary goals informed by extensive stakeholder outreach and engagement for reducing health care provider burden: (1) reduce the effort and time required to record information in EHRs for health care providers during care delivery; (2) reduce the effort and time required to meet regulatory

reporting requirements for clinicians, hospitals, and health care organizations; and (3) improve the functionality and intuitiveness (ease of use) of EHRs.

The report acknowledges that “while different types of administrative burden can affect all participants in the health care system, this report is specifically focused on health care providers directly involved in the delivery of care: frontline health care providers, including physicians and other clinical staff; practice managers and other administrators immediately engaged in the management of care delivery; and care delivery institutions, such as hospitals.”<sup>1</sup>

While discussions about health IT, including within this draft report, have traditionally centered solely on physicians and hospitals, greater attention should be focused on the “end-game,” which is better performance by the health care provider and improved health outcomes. To date, ONC, as well as the Centers for Medicare and Medicaid Services (CMS) have been very exclusive in their development of policies related to EHRs, interoperability, and more, focusing primarily on physicians and hospitals, to the exclusion of physical therapist private practices, postacute care organizations, and other provider types. It is disappointing that smaller providers, who do not have the same leverage and market share as health systems and large organized provider groups do, are left out of many policy discussions. Moreover, while large provider groups/health systems may be on a compatible EHR system, most independent practices use EHRs that are not standardized, making it that much more imperative that these providers, and their specific needs, are front and center in the discussions.

Physicians and hospitals were afforded EHR incentive funding and multiple stages to adopt EHRs and learn how to successfully exchange patient information using certified electronic health record technology (CEHRT), whereas long-term and postacute care facilities as well as nonphysician health care professionals, including physical therapists in private practice, were ineligible to participate in the Meaningful Use EHR Incentive Program (now the Promoting Interoperability category within the Merit-based Incentive Payment System, or MIPS) and have received little direction, as well as time, to adopt and implement comprehensive, interoperable EHR systems that promote care coordination and improve patient outcomes. For the health care system to be patient-centric, all aspects of the health care system, including providers excluded from Promoting Interoperability, need the financial and administrative resources afforded to other providers to fully implement certified health IT and adopt measures that give patients the ability to manage their health information. Therefore, we strongly urge ONC to expand the scope and focus of its work and prioritize the implementation and dissemination of semantically interoperable, standards-based health IT systems that can be used by nonphysician providers, including physical therapists in private practice, and long-term and postacute care facilities, as well as physicians, hospitals, and other health care providers. Seamless, effective, and secure information exchange practices

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<sup>1</sup> Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. Draft for public comment. Office of the National Coordinator for Health Information Technology; 2018:10. <https://www.healthit.gov/sites/default/files/page/2018-11/Draft%20Strategy%20on%20Reducing%20Regulatory%20and%20Administrative%20Burden%20Relating.pdf>. Accessed December 21, 2018.

enabled by such standards-based systems will improve health outcomes and enhance efficiency.

Further, we recommend that ONC provide financial and administrative implementation assistance for physical therapists in private practice, postacute care providers, and other provider types during the move to a more standardized and interoperable environment.

Thank you for your consideration of our comments, outlined in more detail below.

## **Clinical Documentation**

### **Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.**

- *Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.*

While APTA appreciates that ONC is attempting to address EHR-related burden associated with documentation requirements for physician-related patient visits, we are severely disappointed that the report is focused primarily on documentation related to evaluation and management (E/M) documentation guidelines. Moreover, while CMS has instituted a number of regulatory changes to advance its Patients over Paperwork initiative, such efforts have primarily benefited the physician community. We urge CMS to take additional actions that would benefit the entire health care community.

To reduce overall regulatory burden around documentation of patient encounters, we recommend that ONC and CMS work to enhance interoperability among and across providers. Improved interoperability will ease the communication process between providers and promote fewer double entries, in that data will be collected once and used multiple times as it is transmitted among multiple providers.

- *Recommendation 2: Leverage data already present in the EHR to reduce re-documentation in the clinical note.*

We support this recommendation. However, it is important to acknowledge that solo physical therapist private practices, postacute care providers, and other facilities interact with various health care professionals and providers, all of whom may be using different EHR systems. Having a way to share and use information is important. For example, currently with physician and physical therapist workflow, when a physical therapist requires a physician signature on the plan of care, often the physical therapist must fax the plan of care to the physician, which then requires administrative staff to receive the document and incorporate it into the physician's workflow. Following signature, the physician's office must then send the signed plan of care back to the physical therapist, all within a specified timeframe. Being able to incorporate the plan of care into the EHR system in a manner that allows the care plan to enter the workflow of the physician as well as the physical therapist would ease provider burden. While there is functionality for a physician to enter a portal and "sign off" on the plan of care in a few of the leading EHR products for nursing homes and physical therapists, this still increases the physician

burden in requiring them to log onto yet another portal and is not currently available in the average electronic medical record (EMR) used by outpatient physical therapy providers.

- *Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.*

APTA supports this recommendation. We strongly encourage ONC and CMS to engage in an ongoing dialogue with a multitude of stakeholders, including physicians, nonphysician providers, hospitals and health systems, and postacute care facilities. Soliciting input from providers included, and excluded, from Meaningful Use, is critically important to ensuring that electronic documentation tools include features that increase the quality and utility of clinical documentation to enhance communication across the care continuum.

- *Recommendation 4: Waive documentation requirements as may be necessary for purposes of testing or administering APMs.*

We support ONC's recommendation to waive documentation requirements for providers, including physical therapists and other nonphysician providers, to encourage their participation in alternative payment models (APMs), including Advanced APMs. For example, if a physical therapist or other nonphysician provider is a model initiator, we recommend that CMS allow clinical outcomes that assess change in function and other measures, in conjunction with cost data, to guide value-based care decision making and iterative improvements. Further, because data and information technology requirements are a challenge both technically and financially for smaller practices, CMS and ONC should examine solutions that complement current systems. CMS also should encourage APM participants and nonparticipants to work collaboratively with physical therapists, in the determination of early and direct access to physical therapist services when appropriate. The agency also should better promote physical therapist involvement in transition-in-care decision making and discretion in determining the need for referral without penalty.

## **Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.**

- *Recommendation 1: Partner with clinical stakeholders to promote clinical documentation best practices.*

APTA supports ONC's recommendation to disseminate and promote best practices for clinical documentation in EHRs. We would greatly appreciate the opportunity to partner with HHS to continue to work to promote an understanding of documentation best practices. We also encourage ONC to allow professional associations to direct these best practices.

- *Recommendation 2: Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.*

While APTA supports this recommendation, to truly reduce regulatory and administrative burden on the provider community, we strongly recommend that ONC and CMS develop concrete tools and guidance that various health care provider types can use to implement best practices.

**Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.**

- *Recommendation 1: Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization.*
- *Recommendation 2: Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, and payers.*
- *Recommendation 3: Incentivize adoption of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes.*
- *Recommendation 4: Work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.*
- *Recommendation 5: Coordinate efforts to advance new standard approaches supporting prior authorization.*

APTA appreciates ONC's recommendations to leverage health IT to improve prior authorization and supports the above recommendations. Requiring a standard set of clinical documentation data elements/claims formatting that is adopted by providers and EHR vendors and accepted by payers with automated or streamlined transmission would help to eliminate the additional time and resources, as well as duplicative documentation, that is associated with the prior authorization process. Particularly significant is the provision of incentives to facilitate such adoption. We also support the recommendation to enhance transparency; requiring prior authorization criteria to be available at the point of care will be beneficial and further contribute to burden reduction. Moreover, while APTA supports appropriate utilization management to promote the delivery of value-based care, we contend that current prior authorization programs used by Medicare Advantage (MA) plans exponentially increase administrative burden while simultaneously adversely impacting patient access to medically necessary services and creating a systematic focus on volume of services.

Prior authorization substantially increases administrative burden and the possibility of inadvertent error and is in direct conflict with contemporary clinical practice. Patients often must undergo a prolonged, burdensome process to obtain treatment authorizations. A delay in authorization may severely hinder a patient's recovery, requiring physical therapists and other providers to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. Additionally, the care authorized by the health plan often disagrees with the health care professional's recommendations.

It is vital that future approaches that support prior authorization recognize a clinician's ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, and full scope of licensure; this would help ensure timely patient access to medically necessary services and streamlined administrative processes. However, current prior authorization programs are not consistent with these objectives. Further, each MA plan's instructions for obtaining prior approval for current and ongoing patients are unclear. Therefore,

to reduce clinician burden and promote standardized data collection, we recommend that CMS incorporate standard language within its contracts that requires MA plans to:

- Use the same standardized request form for prior authorization, developed by CMS, which undergoes the information collection comment request process;
- Accept requests through the same submission mechanism, such as through a provider portal; and
- Adopt a required response period for prior authorization and repeat authorization requests.

Additional ideas for the agency's consideration:

- Adopt a standard list of self-reporting and objective outcome tools by body region, ability to participate in activities, and general health reporting that are commonly accepted.
- Limit prior authorizations to a specified number of visits and not units of service. Authorization of the number of billed units is not appropriate and should be left to the discretion of the provider based on medical necessity. The duration of each intervention should not be arbitrarily specified by the third-party administrator (TPA) or payer by limiting the number of authorized time units.
- Institute a standard under which a provider can obtain delegated credentialing based on adhering to specific criteria, such as that of the Council for Affordable Quality Healthcare (CAQH). Credentialing requirements by many payers far exceeds the requirement for participation in Medicare Part B and impedes access to qualified providers.
- TPAs defer to the MA plan for appeals of denied or reduced care during the prior authorization process. The TPA makes the decision to reduce or deny care based on their evaluation of medical necessity but defers to the plan for the provider to defend their rationale. There should be one entity making the decision and handling the appeal of that decision.
- Create a standard for initial authorization of care that is applied universally across MA plans. This could be a specified number of visits for nonsurgical care and a different number for postsurgical care.
- Adopt standardized template reporting for submission of prior authorization clinical data.
- Mandate that TPAs or utilization management (UM) companies maintain current eligibility information on their enrollees. Authorization approvals that are obtained through these entities must be honored as valid for purpose of payment by the payer. Frequently, data between the payer and TPA/UM company databases do not match, placing the validity of the prior authorization in question.

We also encourage CMS to consider requiring MA plans to adopt a prior authorization process wherein all prior authorizations, whether submitted directly to the MA insurer or to a subcontractor, are submitted through an electronic portal (consistent portal framework). Under such a process, a MA insurer or subcontractor would be required to “deny” an authorization within a set timeframe, such as 24 or 48 hours, allowing 72 hours for the provider to appeal,

again through a similar electronic portal. If the insurer or subcontractor fails to reply within the timeframe, then the authorization would be granted. This type of process would allow the payer to use algorithms—to be reviewed by stakeholder including professional associations—to identify the most blatant instances of abuse and would allow for proper, timely care to beneficiaries.

Further, there is significant inconsistency between CMS and MA plans' requirements when conducting medical review. For example, when submitting documentation in response to an Additional Documentation Request (ADR), providers have to use one process for Original Medicare; a different process for MA insurer #1, yet another process for MA insurer #2, and so forth. If the CMS contractor or MA insurer uses a website for electronic submission, the provider must log into a different portal for each payer. Making the process even more complex is the burden on the provider to locate the data submission location page for each MA insurer and CMS contractor. Even then, when on the submission page, the process is not consistent from one insurer to the next. In fact, we are aware of at least 1 MA insurer that refuses to allow electronic submission, requiring providers to fax the ADR to it.

To decrease burden and substantially increase compliance and interoperability, we recommend that CMS require each MA plan, as well as each CMS contractor (Medicare Administrative Contractor, Recovery Audit Contractor, Supplemental Medical Review Contractor, etc.) to use the same format, structure, and webpage layout, and afford the ability to submit records or correspond electronically. If providers are submitting in the same layout, file structure, transport method, and with a similar webpage layout, then it is incredibly simpler to share the information in a similar way with other health care providers, thereby increasing interoperability.

APTA also recommends that to reduce burden on providers participating in Original Medicare, CMS should require that MA plans use the same definition of medical necessity that exists under Medicare Part B. MA plans commonly use language from the payer's commercial products and not the Medicare definition. In addition, APTA recommends that CMS standardize the Medicare coverage, coding, and billing guidelines that an MA plan may adopt. MA plans often state that they follow Medicare guidelines but then have confusing interpretations of these guidelines regarding the use of Correct Coding Initiative edits, the multiple procedure payment reduction, etc. While such concerns fall outside of the scope of prior authorization, the lack of standardized guidelines between Original Medicare and MA creates confusion among providers, leading to potential loss of documentation integrity, resulting in limited care coordination and collaboration among health care providers, and significantly increasing provider burden without improving the quality of care.

To ensure that patients continue to receive high-quality care and avoid stinting on medically necessary services, APTA suggests that CMS and ONC consider exempting from prior authorization patient populations with certain conditions and clinicians who participate in standardized data collection system and willing to share outcomes; requiring the use of specific performance-based outcome measures; and/or requiring the collection of patient-reported outcome measures that have clinical utility and importance that are meaningful to a diverse set of provider types. Further, to better align with CMS's Patients over Paperwork initiative, we urge CMS to take action toward a goal of reducing unnecessary burden, increasing efficiencies, and

improving the customer experience by eliminating prior authorization or, at a minimum, penalizing MA plans that fail to furnish authorizations within the timeframe listed in the policy. By acting in the spirit of the Patient Protection and Affordable Care Act by protecting MA enrollees from arbitrary care denials and restrictions, CMS would help to better ensure patient access to timely, high-quality care that is appropriate for the patient's condition, avoids preventable adverse events, and saves plans, providers, and patients from expending resources on unnecessary services.

Data standards and semantic consistency play an important role in interoperability. "Standards are the means by which electronic government can achieve interoperability across departments and agencies, improve their management of supplier contracts, and ensure that key data remain accessible over time."<sup>2</sup> To that end, we urge ONC and CMS to recognize that when providers are forced to comply with varying sets of requirements due to the type of payer or setting, the data standards supporting each provider's EHR system will vary, limiting the capability of such systems to freely exchange data with others. Therefore, to better promote interoperability between and across providers, we recommend that ONC specify site-specific, essential data elements focused on transitions of care; harmonize data elements required by each provider type; and establish semantic standards for each data element.

### **Health IT Usability and User Experience**

#### **Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.**

- *Recommendation 1: Better align EHR system design with real-world clinical workflow.*
- *Recommendation 2: Improve clinical decision support usability.*
- *Recommendation 3: Improve clinical documentation functionality.*
- *Recommendation 4: Improve presentation of clinical data within EHRs.*

APTA supports the above recommendations; however, we recommend that in the final strategy, ONC and CMS be more prescriptive in its strategy. We encourage ONC to recognize the need to establish an infrastructure for information exchange that takes into account the financial needs of providers as well as the need for semantic standards. Currently, there is little to no financial or administrative support for health IT adoption by those who were ineligible to receive Meaningful Use funding, including physical therapists in private practice, long-term care providers, and postacute care providers. Moreover, providers and vendors across these settings, among others, are working to integrate multiple changes, ranging from preparing to participate in the MIPS to the shifting skilled nursing facility (SNF) and home health agency payment systems. These initiatives take time, planning, and resources to implement.

We also encourage ONC to consider how divergent federal requirements may impact a vendor's ability to innovate and advance health IT.

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<sup>2</sup> Davies J, Harris S, Crichton C, et al. Metadata Standards for Semantic Interoperability in Electronic Government. <http://www.cs.ox.ac.uk/people/jeremy.gibbons/publications/metadata-egov.pdf>. Accessed December 21, 2018.

**Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.**

- *Recommendation 1: Harmonize user actions for basic clinical operations across EHRs.*
- *Recommendation 2: Promote and improve user interface design standards specific to health care delivery.*
- *Recommendation 3: Improve internal consistency within health IT products.*
- *Recommendation 4: Promote proper integration of the physical environment with EHR use.*

**Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.**

- *Recommendation 1: Standardize medication information within health IT.*
- *Recommendation 2: Standardize order entry content within health IT.*

Here, APTA urges caution, as all clinician disciplines do not use an EHR in the same fashion, nor do they collect the same data. There are a large array of order entries (i.e. medications, laboratory tests, admissions, radiology exams, referrals, and procedures) and various providers will require varying aspects.

- *Recommendation 3: Standardize results display conventions within health IT.*

APTA encourages and supports the use of data standards for both identifying the item that is referenced and the results that are provided. The actual display of the results should be a user preference. For example, some may wish to view the changes for a standardized test as a list and others may prefer it to be in the form of a bar graph. The underlying understanding what the test is and what the response is shall be the same for all EHRs. In addition, and as stated in previous comments, APTA recommends that ONC recognize the need to adopt classification of health and health-related domains within certified EHR technology, specifically International Classification of Functioning, Disability, and Health (ICF).

ICF was officially endorsed by all 191 WHO member states in the 54th World Health Assembly in 2001 as the international standard to describe and measure health and disability. ICF is operationalized through the WHO Disability Assessment Schedule (WHODAS 2.0).<sup>3</sup> ICF describes health and health-related domains using standard language; is used by physical therapists, among other rehabilitation professionals; and promotes the delivery of coordinated, collaborative care. Different approaches and technical solutions exist for integrating the ICF in EHRs, such as combining the ICF with other existing standards for EHRs or selecting ICF codes with natural language processing.<sup>4</sup> Adopting ICF terminology within EHR systems could advance data sharing and reuse by EHRs and advance the practice of physical therapy and

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<sup>3</sup> International Classification of functioning, Disability and Health. <http://www.who.int/classifications/icf/en/>. Accessed December 21, 2018.

<sup>4</sup> Martiz R, Aronsky D, Proding B. The International Classification of Functioning, Disability and Health (ICF) in Electronic Health Records. A systematic literature review. *Appl Clin Inform.* <https://www.ncbi.nlm.nih.gov/pubmed/28933506>. Accessed December 21, 2018.

research. Moreover, this would allow physical therapists to contribute their unique clinical perspective to other health care providers in a more meaningful fashion.<sup>5</sup>

Therefore, APTA strongly recommends that ONC includes the use of ICF as the documentation terminology to represent patient problems in future editions of certified EHR technology. The Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) and LOINC taxonomy are insufficient to describe patient problems as it relates to mobility, activities and participation, and associated environmental factors. In short, SNOMED CT does not accurately represent physical therapist practice. Moreover, currently LOINC terms are a broader grouping of ICF terms. Incorporating ICF into CEHRT will help to facilitate communication between health care providers as well as better enable physical therapists and other rehabilitation professionals to better describe an individual’s health, function, and disability.

**Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.**

- *Recommendation 1: Increase end user engagement and training.*
- *Recommendation 2: Promote understanding of budget requirements for success.*

APTA strongly supports these recommendations. It is critically important that health care providers incorporate health IT into a meaningful planning and ongoing budget management process. Unfortunately, many providers fail to understand how to effectively evaluate IT initiatives and align them within their budgets. ONC should develop resources and educational materials that discuss how providers may implement a budget that appropriately accounts for information technology. We also encourage CMS and ONC to better recognize and understand the time and costs associated with training, testing, and entering data into an EHR. For example, CMS did not calculate the burden on providers related to training and testing of EHR data entry related to the new postacute care payment models—the SNF Patient-Driven Payment Model (PDPM) and Home Health Patient-Driven Groupings Model (PDGM). And while CMS regularly calculates the time it will take to enter a value into an EHR, it often is a severe underestimate of the actual time. For example, CMS reported it should take a SNF provider 30 seconds to enter Section GG information into the Minimum Data Set; however, it might actually take 2-3 minutes, given the time associated with opening the software, navigating to the correct page, entering the data, verifying and saving the data, and logging back out.

- *Recommendation 3: Optimize system log-on for end users to reduce burden.*
- *Recommendation 4: Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.*

APTA support efforts to reduce clinical burden through better alignment of the EHR with optimal workflows for care delivery, clinical decision making, and other tasks. We recommend that ONC provide additional administrative support to assist smaller providers and those who did

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<sup>5</sup> Vreeman, DJ, Richoz, C. Possibilities and implications of using the ICF and other vocabulary standards in electronic health records. *Physiother Res Int.* <https://www.ncbi.nlm.nih.gov/pubmed/23897840>. Accessed December 21, 2018.

not receive funding associated with Meaningful Use. It is critically important that all providers understand the learning options available in their EHR product to ease the log-on process.

## **EHR Reporting**

### **Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.**

- *Recommendation 1: Simplify the scoring model for the Promoting Interoperability performance category.*

APTA appreciates that CMS is working to simplify the requirements in the Quality Payment Program (QPP), specifically the Promoting Interoperability category within MIPS. While we agree that CMS should continue to explore new incentives within QPP, as well as invest in technical assistance for providers to improve understanding and success within the reporting program, it is critical that CMS offer assistance to physical therapists and other nonphysician providers, particularly small and rural providers, in the form of funding and technical support to assist them in preparing for and participating in MIPS and Advanced APMs, as well as guidance on how to reduce administrative burden. As these providers are often the sole provider for a region and face serious financial concerns and a lack of funding, payment models must consider their unique situation or risk excluding swaths of the population from participation in QPP. We request that ONC and CMS provide appropriate resources and support, including implementation assistance and/or consultant support, to physical therapists in private practice, postacute care organizations, and other settings as they adopt and optimize certified EHRs, to better enable these providers to participate in these new models of care.

We also recommend that ONC and CMS consider providing incentives for any provider that tests a Continuity of Care (CCD) document and scores above 80%, for example. ONC has the testing functionality in place; however, providers need incentives to use this portal for testing. This would significantly increase interoperability.

Other types of support CMS should offer include:

- Education on risk sharing.
- Guidance on interdisciplinary collaboration and data sharing.
- Education on required data elements.
- Education on data analysis and iterative practice changes based on results.
- Physician/referral source education on direct access to physical therapy for musculoskeletal conditions.
- Education on total cost of care and how to assess upstream and downstream costs impacts.

Additionally, CMS should provide guidance and support to providers on interoperability. It also is important for CMS to continue to support the development and success of professional registries as we move toward outcomes-based payment and advanced quality-reporting structures that will rely heavily on electronic data submission. Development of these registries has been spurred by the need to create meaningful quality measures to assist providers in the shift to

value-based payment and models of care. These registries will be critical to the success of innovative payment models in the future, as they have the ability to deliver real-time data to providers for monitoring, assessing, and responding to new and dynamic models of care delivery.

In 2017, APTA launched the [Physical Therapy Outcomes Registry](#), which captures relevant data from EHRs and billing information, and can transform this data into meaningful, intuitive, and actionable feedback for providers on the frontline of patient care. The combination of clinical and quality measurement expertise is essential to ensure that professional registries can be facile and evolve over time with practice. That same expertise is also required to create and maintain clinical practice guidelines and corresponding quality measures for the patient populations served by clinician specialties.

- *Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.*

APTA strongly supports ONC's and CMS's efforts to advance and promote interoperability between providers, including physical therapists in private practice and other nonphysician provider types. However, we reiterate that ONC and CMS have been exclusive in their development of policies related to EHRs, interoperability, and more, focusing primarily on physicians and hospitals, to the exclusion of physical therapist private practices, postacute care organizations, and other provider types. To ensure a successful health care environment, it is critical that burdens be reduced for all providers of the health care team.

Integrated technology plays a vital role in a provider's ability to function in a value-based care system. APTA recognizes that the Medicare Access and CHIP Reauthorization Act of 2015 mandates that providers use CEHRT. However, physical therapists and other nonphysician providers, as well as post-acute care organizations have been exempt from Meaningful Use and have not been afforded the same resources as physicians and hospitals for health IT adoption. Consequently, physical therapists are essentially barred from participating in Advanced APMS and are currently excluded from the Promoting Interoperability category within MIPS due to the lack of physical therapy-specific CEHRT, placing physical therapists at a significant disadvantage and further hindering their ability to succeed in future value-based care models.

While the ONC certification process has established standards and other criteria for structured data that EHRs must use, EHR vendors for physical therapists and other nonphysician providers are unclear as to how to satisfy the 2015 Edition Health IT Certification criteria, given that a number of criteria are inapplicable to these providers. As such, only a limited number of EHRs certified through ONC encompass the necessary components for the documentation and transmission of information regarding physical therapy services. To truly leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs, as well as to incentivize physical therapist and other nonphysician provider participation in QPP and other value-based models in the future, we strongly recommend that CMS allow EHRs used by physical therapists and nonphysician providers to become certified by satisfying a subset of the certification criteria adopted by the HHS Secretary in 45 CFR 170.315.

Another option that ONC could consider is providing incentives for any provider that tests a document and scores above a certain percentage. However, due to the lack of financial and

administrative support available to providers excluded from Promoting Interoperability, we recommend that ONC and CMS continue to make adoption of 2015 EHR certification criteria voluntary for such providers.

We also encourage CMS and ONC to consider modifying the requirements of the 2015 Edition Health IT Certification Criteria for nonphysician EHR vendors. APTA has reviewed the CEHRT categories and identified criteria that may not apply to physical therapist practice:

CEHRT Category	CEHRT Criteria
Clinical Processes	<ul style="list-style-type: none"> <li>• Computerized provider order entry (CPOE) medications (<i>prescribing</i>)</li> <li>• CPOE laboratory</li> <li>• Drug-drug, drug allergy interaction checks for CPOE</li> <li>• Drug-formulary and preferred drug list checks (<i>CPOE</i>)</li> <li>• Implantable device list</li> </ul>
Care Coordination	<ul style="list-style-type: none"> <li>• Electronic prescribing* (for medications)</li> </ul>
Public Health	<ul style="list-style-type: none"> <li>• Transmission to immunization registries</li> <li>• Transmission to public health agencies—syndromic surveillance</li> <li>• Transmission to public health agencies—reportable laboratory tests and values/results</li> <li>• Transmission to cancer registries</li> <li>• Transmission to public health agencies – electronic case reporting</li> <li>• Transmission to public health agencies – antimicrobial use and resistance reporting</li> <li>• Transmission to public health agencies – health care surveys</li> </ul>
*Electronic prescribing may be utilized for referrals and DME	

Additionally, several data elements are included in the Common Clinical Data Set that would not be relevant in typical physical therapist practice including: laboratory tests, laboratory values/results, immunizations, and unique device identifiers for a patient’s implantable devices. We note, however, that for purposes of testing a CCD, an EHR would only need a plan to receive the lab values, etc. Such information can be very valuable to physical therapist practice and might be valuable to send and/or receive in a CCD.

Although the above CEHRT criteria should not be required for health IT used by physical therapists to satisfy the CEHRT definition, it is critical that technology used by physical therapists affords them the ability to receive a medication list. This technology also must allow physical therapists to receive data from multiple encounters that includes the dosage, frequency, and the administration of the medicines, as well as potential drug interactions. The physical therapist also must be able to document patient comments related to medication use. Further, it is important that physical therapists have technology that enables them to access laboratory and diagnostic imaging values and results, as well as record, change, and access diagnostic imaging orders. We recognize, however, that the majority of EHRs used by physical therapists do not currently have the capabilities described above and that there is likely to be an increased cost for such technology. To modify and build upon the existing technological structure to satisfy future CEHRT requirements requires significant financial investment and is time-consuming and disruptive to workflow. Therefore, we recommend ONC and CMS afford EHR vendors and nonphysician providers, including physical therapists, a transition period of 3-5 years to ensure such stakeholders have ample opportunity to develop and adopt certified technology.

APTA strongly encourages ONC and CMS to work together to modify the 2015 Edition Health IT Certification Criteria for physical therapy and other nonphysician EHR vendors. We also recommend that prior to finalizing the modified certification criteria, CMS and ONC collaborate with a broad group of multi-stakeholder groups on the development and implementation of modified health IT certification criteria to better understand how to incentivize adoption of health IT that can generate and exchange standardized data and supporting documentation. Again, testing of a CCD or other data exchange document could move this needle forward in the future.

- *Recommendation 3: Reduce burden of health IT measurement by continuing to improve current health IT measures and developing new health IT measures that focus on interoperability, relevance of measure to clinical practice and patient improvement, and electronic data collection that aligns with clinical workflow.*

APTA recommends that ONC require certified EHRs to be interoperable and able to share information with professional societies, including professional societies' registries. As payment reform moves from process-oriented performance metrics (eg, checklists) to outcome-oriented performance metrics (eg, how patients feel and function based on their self-report), EHRs need to keep pace. Currently, very few EHRs are able to collect patient-reported outcome (PRO) questionnaires of how patients feel and function. They also lack meaningful ways to display this information to clinicians and patients (eg, graphs of symptoms over time).

Moreover, EHRs of the near future need the capability to act on concerning questionnaire responses as well as clinical reported outcomes. This involves electronic workflow for PROs (tracking completed PROs and flagging those that need phone calls about concerning symptoms); email alerts to clinicians for concerning symptoms; and displaying clinical decision support tailored to the symptom reported, health condition, disease stage (eg, cancer stage), and patient characteristics (eg, age). With these EHR capabilities, payers would be able to implement and use PRO-based performance metrics that can be adjusted for patient characteristics (case-mix) and compared across practices to identify high- and low-quality

care. Without these capabilities, payment reform toward outcome performance metrics will be stalled and potentially fail. It is important to also include clinician-reported outcomes. For example, a patient after rotator cuff surgery and rehabilitation might increase shoulder range of motion by 100 degrees and strength by 2 grades. However, the patient's PRO might be comparing themselves to their status from 3 years ago rather than reflect the progress they have made in therapy. In this instance, there is value in both types of measures.

The integration of health information technologies into the practices of nonphysician providers is equally important in improving the quality of care delivered to patients. In particular, the physical therapy profession has made several strides over the past decade to promote the use of health IT, and we are currently exploring how to use these tools to advance the delivery of physical therapy and to effectively measure patient outcomes. It is critical that the promotion and adoption of health IT is approached comprehensively; valid patient assessment tools, clearly identified health outcomes, interventions based on sound science and evidence, recognition that individuals with the same condition often present differently, and inclusion of a wide range of health care providers in health IT adoption plans must be appropriately accounted for and considered.

- *Recommendation 4: To the extent permitted by law, continue to provide states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers.*

APTA strongly supports this recommendation. It is critical that HHS continue to provide states with federal Medicaid funding to promote the advancement of health IT. This funding also needs to support nonphysician providers and especially those in independent practice.

- *Recommendation 5: Revise program feedback reports to better support clinician needs and improve care.*

Reports and program feedback need to be standardized within CMS and among all CMS contractors, in order to support clinician needs and intentions to improve care. The review of reports could be an additional implementation support service provided to clinicians, which in turn would support care improvements.

## **Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.**

- *Recommendation 1: Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting.*
- *Recommendation 2: Adopt additional data standards to makes access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals.*
- *Recommendation 3: Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.*

APTA encourages CMS and ONC to recognize the value of standardizing the submission of data to all Medicare contractors, as well as to MA insurers. This feature alone would increase interoperability, allowing for data to be standardized, pulled, and submitted directly from the EHR, while also decreasing provider burden. At a minimum, there should be a ceiling on the number of varying data submission processes.

**Strategy 3: Improving the value and usability of electronic clinical quality measures while decreasing health care provider burden**

- *Recommendation 1: Consider the feasibility of adopting a first-year test reporting approach for newly developed electronic clinical quality measures.*
- *Recommendation 2: Continue to evaluate the current landscape and future directions of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project.*
- *Recommendation 3: Explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives.*

APTA supports the above recommendations; however, we also encourage ONC to identify ways to pull quality measure data reporting directly from the software. This, in turn, likely will require ONC to provide additional financial and technical support to the software vendors.

**Public Health Reporting**

**Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.**

- *Recommendation 1: HHS should convene key stakeholders, including state public health departments and community health centers, to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms.*

APTA strongly recommends that HHS convene key stakeholders to establish standardized processes and data sets required for interoperability, including:

- Individual authentication (eg, “how do we know it’s you,” and “how do we know it’s the right you”).
- Individual authorization for data use (starting with the Trusted Exchange Framework and Common Agreement requirements).
- Establish, test, and demonstrate incentives and payment models that encourage providers who were not eligible for funding through the Health Information Technology for Economic and Clinical Health Act—and thus may lack or lag behind in the adoption of health IT—to implement health IT solutions and effectively participate in the exchange of standardized information.

- *Recommendation 2: HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.*

APTA supports HHS's efforts to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers. We strongly recommend that CMS modify quality reporting requirements for all provider types and settings (including physicians and hospitals) to include metrics regarding the collection and communication of information required at transitions, as well as timeliness and completeness metrics, ensuring that we are not adding to providers' burden in complying. We also recommend that CMS base future quality and regulatory reporting on elements in the standardized data set to maintain alignment between clinical needs, reporting requirements, and semantic standardization.

We would greatly appreciate the opportunity to engage with ONC, CMS, and stakeholders as they work to mitigate burden associated with the volume and variability of public health reporting and data collection requirements that use data from health IT systems.

- *Recommendation 3: HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care.*

While APTA generally supports this recommendation, we urge caution here if HHS intends to decrease privacy controls at a time when we are looking to add additional information into the EHR, such as social determinants of health. While we support more seamless electronic exchange of health information for patient care, the information should be meaningful and related to patient health.

## **Conclusion**

APTA thanks ONC for the opportunity to provide comments on the Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. While we support the overarching strategy to reduce regulatory and administrative burden, we continue to have concerns that many of the current and proposed reforms to health IT, including standardized clinical documentation and prior authorization, health IT usability, and EHR reporting, do little to address the burdens facing the nonphysician community, including physical therapists, other rehabilitation providers, and postacute care organizations. Such providers have unique concerns that often are overlooked. Moreover, greater deference should be afforded to these providers due to their exclusion from the former Meaningful Use process and ineligibility for EHR adoption incentives. Without proper funding, any reforms put forth in the draft strategy may prove to be of little benefit to such providers. Consequently, it is difficult for such providers, particularly small and rural providers, to invest in health IT while also facing the pressures of changing Medicare payment methodologies, including the SNF PDPM and home health PDGM, forcing providers to evaluate whether they have the financial capabilities to continue to operate in this space.

We look forward to working with the agency as it finalizes the draft strategy. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at [karagainer@apta.org](mailto:karagainer@apta.org) or 703/706-8547, or Matt Elrod, PT, DPT, lead practice specialist, at [mattelrod@apta.org](mailto:mattelrod@apta.org) or 703/706-8596. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD  
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy  
President

SLD: krg