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**Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3**

Dear Acting Administrator Slavitt,

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the proposed rule: Medicare and Medicaid Programs; Electronic Health Record (EHR) Incentive Program—Stage 3. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

As the nation's healthcare system aims to improve quality, safety, and efficiency of care, the ACS supports the meaningful use (MU) of EHR technology to meet these goals. CMS proposes Stage 3 to be the third and final stage of the MU program. ACS appreciates the proposals in the rule that will help reduce burden and offer more opportunities for providers to participate in the Medicare MU program.

However, since the program has moved into a penalty-only phase, we believe that it is critically important for CMS to make the program even more meaningful, relevant, and flexible for providers in order to encourage new and continued participation. The ACS believes that CMS should develop a warning system for EPs who are at risk for penalties and provide EPs with a remedy period before being subject to a penalty. For a program that lacks business operations for early detection and prevention, the MU program has heavy penalties without a remedy period built in.

Our comments focus on issues affecting eligible professionals (EPs) and are presented in the order in which they appear in the proposed rule.

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## Meaningful Use Requirements, Objectives, and Measures for 2017 and Subsequent Years

### Definitions across the Medicare Fee-for Service, Medicare Advantage, and Medicaid Programs

#### *Uniform Definitions*

The Centers for Medicare & Medicaid Services (CMS) is proposing a single set of criteria for Stage 3 of the EHR Incentive Program and eliminating other stages of the program. CMS also proposes that Stage 3 will be optional for EPs in 2017 and mandatory for all EPs in 2018. In addition, CMS is proposing to eliminate the current 90-day EHR reporting period for EPs demonstrating MU for the first time in the Medicare side of the program.

ACS encourages CMS to offer as much flexibility as possible to newly participating EPs and retain the practice of allowing first-time participants to report for a 90-day EHR reporting period. Removing flexibility may further discourage program participation and will add unnecessary burden to EPs participating for the first time. ACS also believes that EPs should be allowed to participate in other stages of the program and gradually work up to Stage 3 instead of requiring all participants to be in Stage 3 in 2018.

#### *MU Stages*

CMS has made several proposals with regard to the varying stages of MU. CMS proposes that participation in Stage 3 of the program would be optional in calendar year (CY) 2017. Therefore, EPs would be able to participate in either Stage 1, 2, or 3 in CY 2017. It would also give an EP the option, for example, if they were in Stage 2 in 2016, to either stay in Stage 2 in 2017 or progress to Stage 3 in 2017. However, all EPs (including first time participants) regardless of their prior participation in the EHR Incentive Program would be required to satisfy the objectives and measures of Stage 3 in CY 2018. CMS believes that reporting on a single set of objectives and measures will reduce burden on providers and will help facilitate interoperability, patient engagement, health information exchange, and also help improve outcomes. Additionally, CMS proposes that all EPs would be required to use EHR technology certified to the 2015 edition for a full CY in 2018.

The ACS strongly encourages CMS to maintain as much flexibility as possible for the EHR Incentive Program. While we understand that requiring all

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participants in the program to participate in the same stage of the program may help facilitate interoperability and other goals, EP's engagement in the program should be a higher priority, and therefore EPs should be allowed to gradually move into various stages of the program similar to how the program has progressed to date. Although CMS does not anticipate there to be any issues that will affect the availability of EHRs, or the ability of any individual EPs to implement 2015 certified EHR technology in CY 2018, we encourage CMS to allow a 90-day reporting period for all providers in CY 2018 in the event there are any unforeseen delays or technology barriers. We note that CMS has recently proposed to re-instate a 90-day reporting period option for 2015, the year designated for adoption of the 2014 Edition of Certified EHR Technology, and we fully expect that the first year in which the next edition of EHR technology must be adopted would likewise benefit from a 90-day reporting period. Otherwise, we are concerned that large numbers of EPs would fail to satisfy MU requirements that year and incur future payment adjustments.

### *Criteria for MU Stage 3*

After analysis of the performance rates of the objectives and measures currently available for Stages 1 and 2 of the MU program, CMS has proposed several changes to the structure of MU Stage 3. CMS notes that they considered recommendations provided to them by various stakeholders. Some of these recommendations included allowing EPs to fail any two objectives and still meet MU, or even allowing EPs to meet program requirements by removing all thresholds. CMS states that it intends to continue to require EPs to meet the objectives and measures of MU rather than allowing them to fail on any objectives or removing measure thresholds. CMS mentions that it is proposing to reduce provider burden and simplify the program by aligning reporting periods and clinical quality measure (CQM) reporting with other programs. Additionally, CMS is proposing to remove the "core" and "menu" measure distinction and remove redundant, duplicative, and topped out measures.

ACS urges CMS to make the EHR Incentive Program more flexible for specialists such as surgeons who may not be able to satisfy all of the objectives and measures of the program. While CMS proposes to provide flexibility for reporting measures on certain objectives discussed in greater detail below, there needs to be even more flexibility provided in the program to prevent EPs from receiving penalties for simply failing to report successfully on just one measure. The program should move away from using an "all or nothing" approach for avoiding penalties. ACS recommends that CMS consider revising objectives and measures to have overall lower thresholds, or giving EPs options to choose to report a minimum number of objectives in order to avoid

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receiving a penalty. As stated earlier, the Medicare MU program has moved away from offering incentive payments to EPs and moving into a penalty-only phase. Therefore, it is critical that CMS think of more flexible options for EPs.

### *Electronic versus Paper-Based Objectives and Measures*

Currently in Stages 1 and 2 of the program, EPs are either required or allowed to include paper-based formats for certain objectives and measures. EPs can print, fax, mail, or produce a paper document to manually count these actions towards satisfying a measure. However, for Stage 3, CMS proposes to only allow electronic formats to count towards meeting measures for the purposes of the Stage 3 objectives and measures. ACS believes that requiring electronic-only formats for inclusion in Stage 3 objectives and measures will be difficult for providers especially in areas where electronic access for patients is limited. This may also have the unintended consequence of limiting other non-electronic forms of communication with the patient due to the additional administrative burden. CMS should consider maintaining flexibility in allowing paper-based formats to continue to count towards meeting the objective, especially if an EP's patient population prefers it.

### *Advanced EHR Functions*

After review of the current Stages 1 and 2 objectives and measures, the recommendations of the Health Information Technology (HIT) Policy Committee, and the goals of the Health Information Technology for Economic and Clinical Health Act, CMS proposes a total of eight objectives with corresponding measures. CMS believes that these key areas represent the advanced use of EHR technology and align with other important health improvement goals. These eight objectives include:

1. Protect Patient Health Information
2. Electronic Prescribing (eRx)
3. Clinical Decision Support (CDS)
4. Computerized Provider Order Entry (CPOE)
5. Patient Electronic Access to Health Information
6. Coordination of Care through Patient Engagement
7. Health Information Exchange (HIE)
8. Public Health and Clinical Registry Reporting

These objectives would apply to Stage 3 of MU beginning in 2017 (if an EP chooses to meet Stage 3 requirements that year). In 2018, all EPs would be required to successfully attest to these eight objectives and their corresponding

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measures, or meet the exclusion criteria for the measures, in order to avoid receiving a penalty.

### *Flexibility within MU Objectives and Measures*

CMS is proposing flexibility within certain Stage 3 objectives and measures by allowing EPs to meet the thresholds for two out of three associated measures. However, EPs would still need to attest to the results of all of the numerators and denominators. ACS appreciates CMS' willingness to provide more flexibility into the program, but is concerned about the higher threshold amounts and the arbitrary percentages attached to each measure. Our concerns are expressed in more detail in the section below. In addition, we would ask that CMS not require EPs to attest to the numerators and denominators for the measures they have chosen not to satisfy, since this would help reduce the reporting burden.

### *Discussion of the Relationship between a Stage 3 MU Objective and its Associated Measures*

CMS is proposing eight objectives with associated measures for Stage 3 of the MU program. Our comments address seven of the eight proposed objectives.

#### Objective 2: eRx

CMS proposes that 80 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using certified EHR technology. CMS also proposes that EPs who practice in a state where controlled substances can be electronically prescribed, can include these prescriptions as "permissible prescriptions" that count towards satisfying the measure since many still encounter administrative barriers to e-prescribing controlled substances. CMS proposes to retain the exclusion for this measure for EPs who write less than 100 permissible prescriptions during the EHR reporting period. ACS believes that controlled substances should not count towards 100 permissible prescriptions when determining the eligibility for this exemption.

We support CMS' proposal to give EPs who prescribe controlled substances the option to include these prescriptions in the numerator and denominator of this measure. However, we believe that this decision should be made by the EP. EPs who do not choose to include controlled substances in their numerator and denominator, even if they live in states where it is allowed to report them electronically, should not be required to include these prescriptions for this measure. We presume that CMS intended to give individual EPs this option but

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seek clarity and confirmation from CMS. ACS believes that the 80 percent threshold is a significant increase from the 50 percent requirement in Stage 2 and should be reduced in the final rule. This threshold is especially high for small practices that may use multiple pharmacies and insurance plans. The ACS supports exempting from this measure, EPs who write fewer than 100 permissible prescriptions during the EHR reporting period, since many of our members currently write very few “permissible” prescriptions.

Additionally, we believe that eRx is an area where the use of an application program interface (API) will be beneficial. We ask CMS to encourage the EHR vendor environment to allow for free movement of information to a cloud with bi-directional interoperability for APIs so that they can help meet this and other requirements.

### Objective 3: CDS

CMS proposes two measures for this objective.

Measure 1: The provider must implement five CDS interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to a provider’s scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.

Measure 2: The provider enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

The ACS is greatly concerned about the first measure. The current Stage 2 measure which requires implementing five CDS interventions to four CQMs has been extremely challenging for surgeons due to the lack of CQMs relevant to surgery. CMS proposes linking the CDS to high-priority health conditions in the absence of four relevant CQMs and also encourages providers to implement CDS in certain areas, such as preventive care, chronic condition management, and heart disease and hypertension. However, the proposed rule does not elaborate on what is meant by high-priority conditions, but ACS presumes that this would be based on an EP’s judgment regarding what is “high priority” for the EP’s patient population. Otherwise, we are concerned that some would consider “high priority conditions” to be those more relevant to primary care practitioners rather than to specialists.

ACS sees surgical care in five phases: preoperative, perioperative, intraoperative, postoperative, and rehab/post discharge. We believe that both CDS and care coordination need to fit into the phases of surgical care as there

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are needs of the chronically ill during acute surgical care which would benefit from these objectives. The ACS has created risk calculators and frail elderly assessments which can be incorporated into CDS tools, but these need time to complete development and undergo implementation. Until such time, we believe that CMS should either limit the need for surgeons to complete these requirements for matters unrelated to surgery or allow EPs to link CDS to clinical guidelines or to a clinical data registry that provides real-time data on the procedure if there are not four relevant CQMs.

#### Objective 4: CPOE

CMS proposes three measures for this objective.

Measure 1: More than 80 percent of medication orders created by the provider during the EHR reporting period are recorded using CPOE.

Measure 2: More than 60 percent of laboratory orders created by the provider during the EHR reporting period are recorded using CPOE.

Measure 3: More than 60 percent of diagnostic imaging orders created by the provider during the EHR reporting period are recorded using CPOE.

We believe that the thresholds for these measures are too high, particularly for Measures 2 and 3 which required a 30 percent threshold in Stage 2. We recommend that all of the thresholds be consistent, or CMS consider allowing one overall threshold for the objective that EPs can meet using any combination of the three measures.

As we discussed in our Stage 2 comments, we continue to have concerns about the high thresholds for these measures in particular, Measure 2, because we believe that incorporating lab data into ambulatory EHRs, which relies on the exchange of health information, is lagging due to EHR vendor resistance. We have heard anecdotally from our membership that entering discrete lab data remains difficult, particularly in situations where there are multiple EHRs or when paper-based orders are used. Therefore, we ask CMS to work with EHR vendors to develop discrete data elements to satisfy measures such as Measure 2 in order to help reduce duplication of efforts on the part of EPs.

On a related note, the Office of the National Coordinator (ONC) proposes to adopt *Health Level Seven (HL7) Version 2.5.1 Implementation Guide: S&I Framework Laboratory Orders (LOI) from EHR, Draft Standard for Trial Use, Release 2—US Realm* (“Release 2”) and *HL7 Version 2.5.1 Implementation Guide: S&I Framework Laboratory Test Compendium Framework, Release 2*,

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(also referred to as the “electronic Directory of Services (eDOS) IG”). However, it is unclear whether the adoption of these standards will address the aforementioned concern, particularly in cases where the order was generated in paper-based format. If not, we urge CMS to work with ONC to ensure that discrete lab values can be transmitted into ambulatory-level EHR systems from the lab regardless of how the order was generated. This will help to ensure important data elements and values from lab testing are appropriately and accurately incorporated into a patient’s medical record.

#### Objective 5: Patient Electronic Access to Health Information

CMS proposes two measures for this objective.

Measure 1: For more than 80 percent of all unique patients seen by the EP:

- (1) The patient (or the patient authorized representative) is provided access to view online, download, and transmit (VDT) his or her health information within 24 hours of its availability to the EP; or,
- (2) The patient (or the patient authorized representative) is provided access to an ONC certified API that can be used by third-party applications or devices to provide patients (or patient authorized representatives) access to their health information, within 24 hours of its availability to the EP.

Measure 2: The provider must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the provider.

Regarding Measure 1, ACS believes that EPs should be given more than 24 hours to provide patients with access to VDT their health information in case there are any unexpected emergencies and technology issues. We recommend CMS change this requirement to provide up to two business days for EPs to provide access to patients’ health information in order to accommodate late day patient encounters immediately prior to a weekend. We note that the comparable Stage 2 requirement, which CMS has proposed retaining for 2015-2017, provides up to four business days.

The ACS supports CMS’ proposal to allow the use of APIs as they would enable patients to access their health information through third-party applications. The use of an API may provide patients with more flexibility in accessing their health information than is currently found in many patient portals. The use of APIs would also be beneficial for providers as they would not have to purchase or implement separate patient portal tools which may be

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costly. CMS notes that some low-cost or free APIs already exist and encourages HIT developers to continue to create low-cost solutions for providers. The ACS supports the use of APIs for patient access to their health information. However, ONC will need to provide more information on the requirements they plan to use to certify APIs to ensure that patient health information is kept secure and confidential. Also, to allow as much flexibility for EPs as possible, the ACS believes that EPs should have the option to choose between the patient portal, API function, or both options. Therefore, we oppose the alternate policies described in the proposed rule.

Regarding Measure 2, CMS states that it will no longer allow the use of paper-based methods for capturing this measure. We ask CMS to maintain the flexibility of allowing providers to use paper-based methods and count paper-based transactions in the measure numerator, especially for EPs who predominately work with a patient population that prefers paper-based resources. Also, should CMS finalize their proposal to only allow electronic-based formats to count towards satisfying this measure, the threshold increase to 35 percent from the Stage 2 requirement of 10 percent, would be too high and should be reduced in the final rule.

#### Objective 6: Coordination of Care through Patient Engagement

CMS proposes three measures for this objective. EPs would need to attest to all three measures, but only meet the requirements of two of the three measures.

Measure 1: During the EHR reporting period, more than 25 percent of all unique patients seen by the provider actively engage with the EHR made accessible by the provider.

A provider may meet the measure by either-

(1) More than 25 percent of all unique patients (or patient authorized representatives) seen by the EP during the EHR reporting period VDT to a third party their health information; or

(2) More than 25 percent of all unique patients (or patient-authorized representatives) seen by the EP during the EHR reporting period access their health information through the use of an ONC-certified API that can be used by third-party applications or devices.

Measure 2: During the EHR reporting period, for more than 35 percent of all unique patients seen by the EP or during the EHR reporting period, a secure message was sent using the electronic messaging function of certified EHR

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Technology to the patient (or their authorized representatives), or in response to a secure message sent by the patient.

Measure 3: Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15 percent of all unique patients seen by the EP during the EHR reporting period.

ACS is greatly concerned about this objective and associated measures. While we understand the importance of allowing patients to be an active part of their health care decision making, we do not believe that providers should be held accountable for the actions of their patients, especially given that the EHR Incentive Program is an “all or nothing” penalty-only program. This is especially true for specialists such as surgeons who often do not have ongoing interactions with their patients due to the emergent nature of surgical care. In addition, patient interest in engaging with the EHR is driven by issues of ease of use and functionality that should perhaps be directed at vendors rather than providers. Lastly, we believe that all three of these measures need to have full interoperability between a cloud-based community and EHRs. Until this is able to happen, EPs should not be penalized for this measure.

Regarding Measure 1, we have heard numerous issues with the current Stage 2 measure that requires only five percent of patients to VDT their health information. Surgical patients often do not see the relevance of connecting with their surgeon via a patient portal especially since they may not see the surgeon more than one or two times. Oftentimes, patients requiring surgery are already connected with their primary care physician’s patient portal. Furthermore, we have heard from many surgeons regarding their patient populations who live in rural areas and do not have access to computers or smartphones due to limited resources. Furthermore, while the use of APIs may help make health information more readily accessible for some patients, it does not guarantee that they will access their information. Similarly, the currently proposed exclusion related to broadband speed is insufficient since that may not be the only barrier. The ACS is supportive of the CMS proposal in *EHR Incentive Program-Modifications to Meaningful Use in 2015 Through 2017; Proposed Rule*<sup>1</sup> which would allow EPs to report on at least one patient to satisfy the VDT measure. We request that CMS finalize this requirement for Stage 3 as well. Due to the “all or nothing” approach in the EHR Incentive Program, many of our members have failed Stage 2 because of being unable to successfully satisfy the VDT measure. We are concerned that increasing the

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<sup>1</sup> Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; EHR Incentive Program-Modifications to Meaningful Use in 2015 Through 2017; Proposed Rule. Vol. 80 FR No. 72.

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percentage threshold for this measure will continue to be a significant issue for our members.

Regarding Measure 2, CMS proposes to include situations such as when EPs communicate with other members of the care team. For the purposes of this measure, CMS specifies that secure messages should contain relevant health information pertaining to the patient such as questions about test results, medications, and other relevant information. However, CMS states that content exclusively related to billing questions, appointment scheduling, or other administrative subjects would not count. ACS believes that these types of secure messages should also be allowed to count towards satisfying this measure as it would make the measure easier to meet while still using the EHR to improve the coordination of care and improve patient engagement. As noted below, we also believe the proposed Measure 2 threshold is too high. We note that CMS has recently proposed that a comparable measure for 2015-2017 could be satisfied if the capability for patients to send and receive a secure electronic message was fully enabled.

Regarding Measure 3, CMS proposes that an EP would have to incorporate health data generated by patients or obtained from what CMS calls “non-clinical” settings. ACS believes that this measure will be very challenging for surgeons to meet. Surgical patients typically communicate their questions and feedback to their surgeon through a telephone conversation. To require surgical patients to communicate electronically in order meet the requirements of this measure seems disruptive to the patient and physician relationship. Until we have more information about the effectiveness of communicating digitally in the postoperative setting, ACS would not encourage CMS to push patients in a direction they would not prefer to change.

ACS appreciates CMS’ intent to provide flexibility for this objective in order to allow an EP to only have to report on two of the three measures. However, for the reasons stated above, we believe that each of these three measures will be very difficult, if not impossible, for surgeons to meet. Furthermore, the thresholds for each of the measures in this objective are arbitrary and inconsistent, which will make reporting even more difficult and confusing for EPs. We therefore recommend that CMS consider making one overall threshold for this objective, such as one patient, and allow EPs to satisfy it using any combination of the three measures-whether it be reporting on one measure or a combination of two or all three.

Objective 7: HIE

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For this objective, CMS proposes three measures. EPs must attest to all three of these measures, but only meet the requirements of two of the three measures.

Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using certified EHR technology; and (2) electronically exchanges the summary of care record.

Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, the provider incorporates into the patient's record in their EHR an electronic summary of care document from a source other than the provider's EHR system.

Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The regulation text states that the EP must implement clinical information reconciliation for the following three clinical information sets:

- 1) Medication review of the patient's medication, including the name, dosage, frequency, and route of each medication.
- 2) Medication allergy review of the patient's known allergic medications.
- 3) Current problem list review of the patient's current and active diagnoses.

For the summary of care record requirement in Measure 1, the Food and Drug Administration's unique device identifier (UDI) is included as one of the common clinical data set elements proposed by ONC for the summary of care document. However, the ONC proposal does not direct the provider/facility to capture that information at the point of care, so it is unclear how it would be captured or if it is even required to be captured. The ACS would therefore like clarification on this issue. More specifically, is the UDI-related policy viewed as an issue of EHR functionality or would it impose obligations on the EPs creating a summary of care record?

For Measure 3, we recommend that the measure description not require reconciliation of all three clinical information sets, but allow the EP to choose one or two of the three. This would be a more natural progression from the current comparable Stage 2 measure, which focuses only on medication reconciliation.

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Furthermore, Objective 7 is another example of an objective with high, arbitrary, and inconsistent thresholds for each of the measures. We urge CMS to consider either 1) reducing each of the thresholds, or 2) allowing for one overall threshold to meet any combination of the three measures, whether it be reporting on one measure or a combination of two or all three. In the case of a single overall threshold, it would obviously be necessary to adopt the same denominator for all of the measures. In this regard, we would encourage CMS to exclude “walk-in” patients never before seen by the provider in measures two and three, since we believe such an expanded denominator would significantly complicate compliance. All three measures should focus on transitions of care and referrals.

#### Objective 8: Public Health and Clinical Registry Reporting

CMS proposes that EPs would need to report on three of the five measures applicable to EPs to satisfy this objective. CMS notes that EPs would be allowed to report on more than one registry for Measures 4 and 5 to meet this requirement.

Measure 1: Immunization Registry Reporting: The EP is in active engagement with a public health agency (PHA) to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system.

Measure 2: Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs.

Measure 3: Case Reporting: The EP is in active engagement with a PHA to submit case reporting of reportable conditions.

Measure 4: Public Health Registry Reporting: The EP is in active engagement with a PHA to submit data to public health registries.

Measure 5: Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry (CDR).

CMS is proposing to provide more flexibility for EPs to make it easier for them to report to public health registries. For Stage 3, CMS proposes that EPs would only have to report on three measures from Measures 1 through 5, or meet the criteria for exclusion, to satisfy this measure. The public health registry requirement for Stage 2 has generally been an issue for ACS members,

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especially immunization registry reporting since immunization records are generally not collected by surgeons.

Of the five measures available for EPs for this objective, ACS believes that Measure 5 would likely be the most relevant to surgeons. We note that CMS proposes to create a centralized public health data repository of national, state and local PHA and CDR readiness expected to be available by the start of CY 2017. Such a repository would be essential to facilitate EP compliance with this objective so that EPs would not have the added burden to search for CDRs. However, for the purposes of the relevant exclusion, we recommend that CMS clarify whether a provider would be allowed to report to a CDR that is applicable to their practice and not be required to submit data to just any available CDR in their jurisdiction. Lastly, we note that CMS proposes an exclusion for all five measures if the relevant PHA/CDR is not capable of accepting the specific standards required to meet the certified EHR technology definition at the start of the EHR reporting period or has not declared readiness to accept the data at the start of such reporting period. ACS strongly supports these proposed exclusions.

### **Reporting on CQMs using Certified EHR Technology by EPs**

#### CQM Requirements for MU in 2017 and Subsequent Years

With regard to CQM reporting, ACS strongly urges CMS to further expand the list of CQMs to include more specialty-specific and meaningful measures into the MU program, or provide exemptions in cases where no relevant CQMs exist. Many of the measures that are currently available are weighted toward primary care and preventive medicine or not relevant to a specialist's scope of practice. In order to satisfy CQM requirements, surgeons are forced to choose measures that they must incorporate into their workflow for purposes of meeting EHR Incentive Program requirements, rather than choose measures that are relevant and meaningful to improving quality of care. We highly encourage CMS to work with specialty societies to develop specialty-specific CQMs for the inclusion in the EHR Incentive Program. We look forward to reviewing the proposals CMS sets forth with regard to CQMs in the upcoming 2016 Medicare Physician Fee Schedule Proposed Rule.

#### *CQM Reporting Period*

CMS is proposing to require a one full CY reporting period for all providers participating in the Medicare MU program, with a limited exception for those participating in the Medicaid MU program for the first time. This would also require CQMs to be reported for one full CY by all EPs. The ACS does not

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support CMS' proposal to require all EPs in the Medicare MU program to have to report on MU requirements for one full CY. We believe that CMS should continue to offer flexibility for first time participants and for all EPs during the first year that a new edition of EHR technology is required, by allowing them to report for a 90-day reporting period. We believe first-time EPs who are trying to align reporting across multiple Medicare programs, should be given the option to report for one full CY if they choose to, but otherwise, would only have to report for a 90-day period within the CY.

### *Reporting Flexibility for EPs in 2017*

CMS proposes that for CY 2017, EPs would have two options to report their CQMs either electronically or via attestation. This flexibility for reporting CQMs would be provided to EPs in CY 2017 since it will be the year that EPs will transition between two versions of certified EHR technology. The ACS supports this proposal. However, beginning in CY 2018, CMS proposes to require electronic reporting of CQMs except in situations where this may not be feasible. We believe that CMS should continue to offer the maximum amount of flexibility as possible for EPs trying to participate in this program and therefore, encourage CMS to continue allowing attestation to be an acceptable method of reporting CQMs, at least through CY 2018.

### **Payment Adjustment and Hardship Exemption**

#### EHR Reporting Period for Determining whether an EP is Subject to the Payment Adjustment for CY 2018 and Subsequent CYs

In the current MU regulations, the EHR reporting period for a payment adjustment is the full CY two years before the payment adjustment year, except for first time EPs who would only be required to report for 90 days. In the Stage 3 proposed rule, CMS proposes the requirement for all EPs to avoid the payment adjustment will be the full CY year two years prior to the payment adjustment year. The ACS does not support this proposal. As stated earlier, ACS believes that first time providers should be given more flexibility to report for a 90-day reporting period instead of a full CY. We also believe that a 90-day reporting period should be available to all EPs in the first year in which they adopt a new edition of EHR technology, for purposes of avoiding a payment adjustment.

#### Exception to the Application of the Payment Adjustment to EPs in CY 2017 and Subsequent Years

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CMS proposes no changes to the hardship exemptions that are currently offered under the MU programs. These exemptions include: insufficient internet access, newly practicing EP, extreme circumstances outside of EP's control, lack of control over the availability of a certified EHR technology for EPs practicing in multiple locations, lack of face-to-face patient interactions, and lack of need for follow-up care. While ACS supports the retention of these hardship exemptions, the ACS strongly believes that CMS needs to expand this list of hardship exemptions to include an exemption for EPs in small practices and for those who are nearing retirement. There are many physicians who are either currently eligible, or close to being eligible for retirement, or who are solo practitioners or part of a small group practice, for whom the cost of investing in an EHR system would be economically burdensome and unfeasible. As a result, some providers may decide to opt out of Medicare, retire prematurely (with negative consequences for patient access and continuity of care), or find themselves forced to join larger systems in order to avoid penalties.

The ACS appreciates the opportunity to offer these comments and we look forward to continuing to work with CMS in order to provide additional feedback regarding MU. If you have any questions regarding our comments or need more information, please contact Sana Gokak, Quality Associate in the Division of Advocacy and Health Policy for questions. She may be reached at [sgokak@facs.org](mailto:sgokak@facs.org) or at (202) 672-1517.

Sincerely,

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