July 9, 2012

Dear Member of Congress:

As the nation's healthcare system is undergoing a transformation in an effort to improve quality, safety, and efficiency of care, the undersigned organizations support the use of EHR technology to implement such changes. However, we have several concerns about the proposed rule issued by the Centers for Medicare and Medicaid Services (CMS): *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2*[1] for the Stage 2 of meaningful use objectives and measures that must be met by eligible professionals (EPs)[2] to ensure receipt of the financial incentives and avoid the penalties specified by the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA authorizes CMS to provide financial incentives for eligible physicians who meaningfully use electronic health records (EHRs). These incentive payments began in 2011 for eligible Medicare physicians. Physicians who have not demonstrated they have met the incentive criteria will face payment reductions in their Medicare payments in 2015.

Specifically, we are concerned that the Stage 2 goals for "meaningful use" of EHR may be too ambitious for small practices. This is a critical issue that could affect thousands of small practices.[3] Over the past several years, there has been a significant upsurge in activity promoting the adoption of EHRs. The federal government has instituted incentives, both positive and negative, to encourage implementation of health IT. However, the significant initial price of implementation remains the greatest barrier to its adoption among small practices.

A study in the March 2011 edition of *Health Affairs* estimated that the total first-year costs of EHR implementation for a five-physician practice to be $233,297, with average per-physician costs of $46,659 – a large expense for any small business to incur.

We continue to be concerned about small practices who do not have and who simply cannot afford health IT. For small practices, the high cost of EHR adoption is not offset by existing financial incentives. To the contrary, practitioners face uncertainty regarding the value they will receive. This is because the initial financial benefits of adoption, if they even exist, are difficult to quantify. Moreover, the expense of adoption is exacerbated by the lack of compatibility standards for electronic systems.

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[1] Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2, 77 FR 13698 (proposed March 7, 2012).

[2] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html

[3] According to the American Medical Association, 60 percent of office-based physicians work in practices of fewer than 10 doctors. According to The New England Journal of Medicine, over 50 percent of physician practices consist of 1-3 doctors.

A. Congress Should Act to Make Changes to the Application of the EHR Incentive Program Penalty.

1. Create a Small Practice Exception from the Medicare EHR Incentive Program Penalty

The undersigned organizations strongly recommend the establishment of a small practice exception for physicians. Physicians in small practices face unique challenges implementing EHRs. These practices have very limited financial, time, and staff resources to devote to EHR implementation. We expect that small practitioners will need more time than larger practices to implement EHRs and meet the meaningful use criteria. These practices play an important role in health care, and we are concerned that without some form of relief younger physicians will be discouraged from opening their own practices. A hardship exception of three years, starting in 2015, would give small practitioners much needed time to ensure a smooth implementation process and promote success in participating in the program.

In line with this, small providers are having a difficult time achieving the meaningful use criteria, and the undersigned organizations believe that these physicians should have more time to comply. In fact, as of April 2012, according to CMS, only 49,757 doctors of medicine or osteopathy received the Medicare incentive payments out of the 156,172 that have actively registered for the program.[4] It is evident that the plurality of the payments have gone to primary care practices and the value of EHRs will only be realized if providers throughout the whole continuum of care are effectively using EHRs. In addition, the Department of Health and Human Services' own data indicates that in 2011, only 57 percent of physicians use EHRs[5], and in most cases they are not using a system that is comprehensive enough to meet the Stage 1 requirements. We ask that CMS allow small providers to be eligible to receive the full EHR bonus payment of $44,000 regardless of the year they begin participating in the Medicare EHR Incentive Program similar to how the Medicaid side of the incentive program is structured.

2. Prohibit the Application of the Medicare Penalty to EPs Successfully Participating in the First Year of the Medicaid EHR Incentive Program

CMS proposes that the EPs who are eligible for a Medicaid EHR Incentive payment in a given year, and who have adopted, implemented, or upgraded certified EHR technology, would not be considered meaningful users of EHRs. Therefore, they could still be subject to a penalty under the Medicare side of the program. Many of the undersigned organizations urged CMS to reconsider this as it would, in effect, mean that all EPs are required to demonstrate meaningful use in the first year of the program regardless of whether they are participating in the Medicare or Medicaid EHR Incentive Programs. The statutory language states that "for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology."[6] The language clearly is intended to provide flexibility to EPs in the Medicaid EHR Incentive Program

[4] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Monthly_Payment_Registration_Report_Updated.pdf
[5] http://www.cdc.gov/nchs/data/databriefs/DB79.pdf
[6] American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, SEC. 4201 (6)(C)(I)(II).123 Stat. 493.

in their first year of participation. By applying the Medicare penalty in their first year of participation in the Medicaid EHR Incentive Program, an EP could be eligible for Medicaid EHR incentive payments and simultaneously incur the Medicare EHR penalty. We do not believe that this is an outcome that the Congress intended, and it would adversely impact all practices – including our nation's small practices.

3. Shorten the Gap Between the Performance Period and the Application of the Penalty

Additionally, CMS proposes that those EPs who receive an incentive for payment year 2013 be exempt from the penalty in 2015. We support this proposal. However, CMS also states that for every year after calendar year 2015 that the EHR reporting period for the penalty would continue to be the calendar year two years prior to the penalty year. We urge Congress to mandate that CMS tie the penalty year closer to the reporting period for the penalty so that there is less lag time between the two. While we have advocated to CMS to decrease the lag time for all of the CMS quality reporting programs, we believe that it is even more applicable to the EHR Incentive Program due to the vast amount of resources that are required to get the EHR in place as well as the amount of preparation time that goes into implementing a system. This two year look-back policy unfairly accelerates the date by which EPs must meet meaningful use requirements to avoid penalties. In order to support improvements in quality, financial incentives (positive or negative) need to be linked to clearly identifiable actions or behavior. The proposed two year lag creates a disconnect between the performance of participating EPs and the financial incentives, and undermines the opportunities for improvement.

4. Limit Application of the Penalty to Near Retirement EPs

Finally, we would like to note that some providers may retire earlier than they otherwise would have due to the economic burdens and costs of investing in an EHR system. Some EPs may decide to opt out of Medicare all together in order to avoid penalties. As mentioned earlier, we support the meaningful use of EHR technology. However, with the increasing health care needs of our society, we simply cannot afford to lose experienced physicians. We would like for Congress to consider introducing legislation to create an exception for those EPs who are either currently eligible or will be eligible for Social Security and retirement benefits by 2014. We believe that this exception should be one year long with eligibility to apply again in each subsequent year, with the availability of the exception sun-setting after 3 years to ensure that physicians who do plan to continue practicing past their social security retirement age are not entirely exempted from the program requirements.

B. Congress Should Make Changes to Address Important Issues Regarding Program Eligibility and to Define Hospital-Based EPs.

According to CMS, hospital-based EPs are not eligible for incentive payments. An EP is considered hospital-based if 90 percent or more of his or her services are performed in a hospital inpatient or emergency room setting. We recommend that CMS implement an additional penalty exception whereby hospital-based EPs who are initially determined to provide 90 percent or more of their services in an inpatient or emergency room setting, but who do not meet the 90 percent requirement in some future year, would nonetheless be considered hospital-based. We

request that CMS examine all EPs who might fall into this category and decide whether these EPs on the borderline of being defined as hospital-based should be considered fully eligible or fully ineligible to participate in the program instead of determining their qualification on a yearly basis.

A less complex approach would be to allow the initial determination that an EP is hospital-based to apply for the rest of the EHR Incentive Program. There are many situations where a provider may make a rational decision not to invest in an EHR because they are considered by CMS' definition to be hospital-based. However, it is a real possibility that in the following year, they could fall somewhat below the 90 percent threshold.

In order to appropriately allocate resources as well as to create coherence in the program, we strongly believe that this determination should be made only once, and that providers should be able to rely on that determination. The undersigned organizations also believe that if CMS is unwilling to provide stability for the entire duration of the EHR Incentive Program, then in order for a provider to adequately and responsibly budget and allocate limited resources, CMS should allow their determination to be valid for five years.

We also ask that Congress urge CMS to expand the definition of hospital-based EPs. An example of where this type of clarification is needed can be found in anesthesiology. The 90 percent threshold means that the overwhelming majority of anesthesiologists, contrary to Congressional intent, are under the purview of the program. Congress intended to exempt anesthesiologists from the program by deeming these providers as hospital-based EPs. The result, however, is that these physicians are subject to penalties based upon criteria never intended for them. For example, although anesthesiologists are never involved in vaccination administration or documentation, the current regulations require them to purchase software used to track patient vaccinations.

C. Congress Should Work with CMS on Issues Regarding Measures Selected for Demonstrating "Meaningful Use."

1. <u>E-Prescribing (e-Rx) Measure</u>

One of Stage 2's "core objectives" calls for EPs to "generate and transmit prescriptions electronically for more than 65 percent of prescriptions." We believe the proposed threshold for e-prescribing is too high and should be kept low, especially for EPs who commonly write prescriptions where electronic transmission is often not permissible. An example would be controlled substances, which do not count towards meeting the 65 percent threshold.

We also remain concerned about the lack of interoperability between small local pharmacies and physician offices. Many pharmacies are simply not equipped to accept electronic prescriptions. According to the Stage 2 proposed rule, exclusions include any EP who writes fewer than 100 prescriptions during the EHR reporting period or does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 25 miles of the EP's practice location at the start of his/her EHR reporting period. We support these exclusions. However, we anticipate that many practices still will have difficulty meeting this objective. CMS should broaden

the exclusion to include other barriers which prevent physicians from meeting the measure's requirements.

2. Patient Portal Measure

Another concern is the core objective calling for providers to "provide patients the ability to view online, download, and transmit their health information within four business days of the information being available to the [eligible professional]." As written, the proposed regulations will require physicians to give more than 50 percent of their patients e-access to their health information; make sure more than 10 percent view, download, or transmit their health information to a third party; and provide more than 10 percent with EHR-generated educational resources. Although we are supportive of patient portals and allowing patients to review and update their medical information, this will be challenging for small practices who cannot afford a patient portal. A smaller practice that is struggling to adopt technology should be permitted to use some other transmission method to get personal health information to patients. In addition, penalizing physicians for the patient's (behavior) failure to participate is unreasonable.

3. Clinical Lab-Test Results Measure

Next, the core objective calling for EPs to "incorporate clinical lab-test results into Certified EHR Technology as structured data" for more than 55 percent of all clinical lab test results could be difficult for small practices. This objective requires incorporating lab data into an EHR to easily capture the data through the exchange of health information. Each lab has a different interface and each health plan has their preferred lab. If you are a low volume user, which most small practices are, the cost to exchange data is not subsidized by the lab and practices are forced to pay a fee per click and interface. Providers should not be penalized for lacking the ability to exchange information when labs have no incentive to communicate with providers.

4. Scope of Clinical Quality Measures (CQMs)

In addition, the undersigned organizations specifically request that when CMS makes its determination on the subset of CQMs to finalize, that the agency include broadly encompassing measures on both primary care and specialties to allow them to participate in the program. Additionally, CMS states that all of the CQMs in Table 8 of the rule will apply to all EPs regardless of whether they are in Stage 1 or Stage 2 of meaningful use in 2014 and 2015 (and possibly subsequent years). While we greatly appreciate this, we have asked that CMS consider allowing this expanded list of CQMs be used for Stage 1 in 2013 rather than having to wait until 2014. Currently in Stage 1, EPs are allowed to report zeros if they don't meet any of the CQMs. Reporting on CQMs will be critical as EPs move forward with becoming meaningful users and ensuring that high quality care is provided to the patient. This expanded list will help EPs to meaningfully use CQMs rather than having to report a zero, and will allow them to better achieve the intent of the program.

We appreciate your attention to these issues specific to the Medicare and Medicaid EHR Incentive Programs. We also maintain our concern that the Medicare EHR penalty is one of several penalties that small practices could face in 2015. Physicians also have the potential to be penalized for failure to participate in the Physician Quality Reporting System (PQRS). CMS has

proposed that both of these penalties will be based on 2013 data. Despite the fact that reporting of clinical quality measures is a key component of the EHR Incentive Program, the reporting requirements are not fully aligned with PQRS. Small practices must currently keep track of two separate sets of reporting requirements with limited resources to do so.

We believe that it will be extremely helpful for clinicians to be able to report through a single streamlined mechanism for multiple CMS programs in order to eliminate confusion, reduce burden, and overall, improve their quality of care. This alignment is a necessary component to creating a coherent strategy for improving the quality of health care in the United States. As part of CMS' efforts to align these programs, we request relief for small practices who face additional challenges meeting multiple program requirements and ask Congress to work with the Agency to continue to identify other areas in which alignment can occur and legislative impediments to making these types of improvements.

We would like to see legislation introduced to fix the issues mentioned above requiring Congressional action. In addition, we urge members of Congress to share all of these listed concerns with officials at CMS via letters, phone calls or in meetings to ensure that small practices remain viable and able to provide quality health care to our country's growing and aging population.

If you have any questions, please contact Dana Halvorson at the American College of Surgeons at dhalvorson@facs.org or 202-672-1502 and Tom Dawson of the National Coalition of Health Providers at 202-628-3729 or tom@americancapitolgroup.com.

Sincerely,

American Academy of Dermatology Association

American Academy of Facial Plastic and Reconstructive Surgery

American Academy of Ophthalmology

American Academy of Otolaryngology—Head and Neck Surgery

American Association of Neurological Surgeons

American Association of Orthopaedic Surgeons

American College of Osteopathic Surgeons

American College of Surgeons

American Congress of Obstetricians and Gynecologists

American Dental Association

American Gastroenterological Association

American Osteopathic Academy of Orthopedics

American Osteopathic Association

American Society for Surgery of the Hand

American Society of Anesthesiologists

American Society of Breast Surgeons

American Society of Cataract and Refractive Surgery

American Society of Colon and Rectal Surgeons

American Society of Metabolic and Bariatric Surgery

American Society of Plastic Surgeons

Congress of Neurological Surgeons

National Coalition of Healthcare Providers

Society for Vascular Surgery

The Society of Thoracic Surgeons