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July 21, 2014

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U.S. Department of Health and Human Services
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Re: Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition

Dear Administrator Tavenner and Dr. DeSalvo,

On behalf of the more than 79,000 members of the American College of Surgeons (ACS), we are writing to provide feedback to the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC HIT) on the proposed rule that would modify the EHR Incentive Program to revise the definition of certified EHR technology (CEHRT). 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. This proposed rule seeks to change the definition of CEHRT as well as the meaningful use stage timeline. Our comments appear in the order they are presented on in the proposed rule.

Provisions of the Proposed Regulations

Proposed changes to the meaningful use stage timelines and the use of CEHRT

Many EHR vendors have expressed concerns with being unable to certify their EHR products to the 2014 Edition of EHR certification due to the short time span between the Stage 2 final rule and the beginning of Stage 2. As a result, there has been a backlog of eligible professionals (EPs) and hospitals intending to upgrade to the 2014 Edition CEHRT. To help alleviate this problem, CMS and ONC are proposing to allow EPs, eligible hospitals (EHs), and critical access hospitals (CAHs) that could not fully implement the 2014 Edition CEHRT for the 2014 year due to delays in the availability of the upgraded software, to continue to use the 2011 Edition CEHRT, or a combination of 2011 Edition and 2014 Edition CEHRT for the 2014 EHR reporting period. The ACS supports this proposal.

2014 Edition CEHRT availability

The three proposed options for the use of CEHRT editions are as follows:

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- 1) Using the 2011 Edition CEHRT only. In this option, EPs, EHs, and CAHs that use 2011 Edition CEHRT for their EHR reporting period in 2014 must meet the meaningful use objectives and associated measures for Stage 1 that were applicable in the 2013 payment year regardless of their current stage of meaningful use.
- 2) Using a combination of 2011 and 2014 Edition CEHRT. In this option, all EPs, EHs, and CAHs using a combination of 2011 Edition CEHRT and 2014 Edition CEHRT for their EHR reporting period in 2014 may choose to meet the 2013 Stage 1 objectives and measures or the 2014 Stage 1 objective and measures, or the 2014 Stage 2 objectives and measures.
- 3) Using the 2014 Edition CEHRT for 2014 Stage 1 Objectives and Measures in 2014 for providers beginning Stage 2. In this option, providers who were scheduled to begin Stage 2 in 2014 and were unable to begin due to delays in the implementation of the 2014 Edition CEHRT, would have the option to report on Stage 1 objectives and measures for 2014.

For any of these three options, the proposed rule notes that EPs who were unable to fully implement the 2014 CEHRT due to delays in its availability would need to attest to this when they submit their attestation for the meaningful use objectives and measures. While the ACS is appreciative of these proposed changes, we also believe that EPs who choose to use the 2014 Edition CEHRT and attest to 2014 meaningful use Stage 2 as scheduled for this year, should not be subject to penalties in 2016, if they are unsuccessful due to the uncertainty of the software environment.

Furthermore, in the rule, CMS and ONC state that this proposal does not change the timelines for 2015 meaningful use reporting. Current policy requires providers who achieved meaningful use prior to 2014 to report on meaningful use for a full year in 2015. However, under this new proposal, providers may use 2011 CEHRT in 2014, and 2014 CEHRT may not even be available until after the start of 2015. Once implemented, providers will need time to train and hire new staff, implement safety precautions and adjust workflows prior to starting the 2015 program year. Therefore, we believe that a full year reporting requirement in 2015 would not be reasonable. ACS strongly encourages CMS and ONC to alter the 2015 reporting period to allow for a 90 day reporting period for all providers.

The ACS requests that CMS and ONC clarify their expectations for the EHR Incentive Program for 2014 and future years. If this proposal is finalized, CMS and ONC will need to provide tremendous education and outreach to providers and their staff on these modifications.

Also, we seek clarification on the following:

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1. As currently finalized in the Stage 2 final rule, first time EPs need to begin their 90 day reporting period no later than July 1, 2014 and submit their attestation to CMS by October 1, 2014 in order to avoid the 2015 EHR program penalty. Given that this proposed rule will be finalized well after the July 1 deadline for first time EPs to begin reporting, will CMS and ONC give EPs who begin after July 1 additional time to submit their attestation such that they will avoid a penalty? We are concerned that this rule will not be finalized in time to provide meaningful flexibility to first time EPs who need to begin no later than July 1 as well as established EPs who must begin their reporting period no later than October 1.

2. Will EPs who have applied for an EHR Incentive Program exception by July 1, 2014 and specifically stated that they are having “2014 vendor-related issues” be required to submit data on 2011 and/or 2014 Edition CEHRT should this rule be finalized, or will they be exempted for calendar year 2014? A vendor’s inability to achieve the required certification standards is out of the physician’s control, and therefore EPs should still be eligible to qualify for this particular hardship exception to avoid penalties in 2015 and in future program years.

3. We seek clarification of the phrase “fully implement,” and encourage CMS and ONC to consider the significant time and resources that are necessary to train staff, adjust for new workflows and invest in new resources to ensure meaningful implementation of newly certified technology, even after it is initially installed.

Extension of Stage 2

CMS and ONC are proposing a one year extension of Stage 2 so that Stage 3 will begin in 2017 for EPs. This delay will allow CMS and ONC sufficient time to focus efforts on patient engagement, interoperability, and health information exchange requirements. The ACS strongly recommends that CMS and ONC carefully analyze participation data from both Stages 1 and 2 of the program before finalizing requirements in Stage 3. We have expressed concern in previous comments regarding measures with onerous or irrelevant requirements. For example, one Stage 2 measure requires using clinically relevant information to identify and send patient reminders for preventive/follow-up care. The ACS believes that this measure may not be appropriate for all specialists. While it makes sense for a primary care physician to send reminders to his or her patients with one or more chronic conditions, surgeons many times treat a patient for an acute, time-limited condition, such as appendicitis or acute otitis. Thus, sending patient reminders should not be a core requirement for care of all patients. Another Stage 2 measure requires that clinical summaries are provided to patients within one business day for more than 50 percent of office visits. We continue to believe that the threshold for this measure is too high and that the one business day requirement is burdensome for providers. These are

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examples of Stage 2 measures that should be carefully analyzed to see how many EPs were able to successfully comply with them. ACS is greatly concerned that changes are being sought without considering how relevant measures are to providers based on the type of care they deliver, especially specialists, and whether reporting on these measures in Stages 1 and 2 of the EHR Incentive Program has resulted in demonstrable care improvements. Information should be collected through validated survey methodologies on how providers are performing before making recommendations for new criteria or increasing reporting thresholds in Stage 3 or future iterations of the program.

Clinical Quality Measure (CQM) Submission in 2014

The proposed rule states that due to limitations in the EHR Registration and Attestation System, the CQM submission will be dependent on which edition of the CEHRT a provider uses for the 2014 EHR reporting period. For example:

- If a provider elects the 2011 Edition CEHRT, they will be required to report on the set of 44 measures finalized in the Stage 1 final rule. EPs reporting for the first time would have to report for 90 consecutive days and report on **three core or alternate core measures and three additional CQMs**.
- An EP who reports using a combination of 2011 and 2014 Edition CEHRT and attests to the 2014 Stage 1 objectives and measures or the Stage 2 objectives and measures will have to report CQMs using the criteria finalized in the Stage 2 final rule- **nine CQMs covering at least three National Quality Strategy (NQS) domains**.
- Those EPs who are able to use the 2014 Edition CEHRT, would also be required to report on **nine CQMs regardless of which stage they are in**.

The CQM component of the program has been particularly challenging for surgeons. There are not enough relevant and meaningful measures for surgeons to report. CMS should work with specialty societies to develop specialty-specific clinical quality measures in the EHR Incentive Program. CMS should also be clear about whether they plan to post CQM information on the Physician Compare Website in the future.

Furthermore, current policy allows providers to use 2014 CEHRT to report quality measures once for both the Physician Quality Reporting System (PQRS) program and the EHR Incentive Program. However, because of issues outside of their control, many providers may still be on 2011 CEHRT, which may not support electronic quality reporting. These providers will need to report to PQRS via claims reporting, and then to meaningful use via manual attestation. We are concerned that this duplicative reporting will be confusing and burdensome to many providers, and therefore request that PQRS participation be recognized as sufficient to satisfying the CQM portion of the meaningful use program this year.

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Although the options in this proposed rule address concerns about the 2014 certification, it does not address the overarching issues with the EHR Incentive Program including the lack of interoperability and flexibility in the program. The ACS believes that CMS should encourage ONC to make interoperability a top priority, as sharing health information over EHR systems are key to reducing costs, improving efficiency and quality, and increasing patient safety. CMS must also 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—the inability to satisfy even one objective or measure will penalize EPs. The ACS strongly encourages CMS to provide flexibility to providers in this scenario. The program should move away from using an “all or nothing” approach for receiving incentive payments and avoiding penalties, and similar to other quality programs, consider setting a lower threshold for avoiding a penalty. Lastly, CMS should also give providers more flexibility to choose reporting options that are most relevant to their practice by emphasizing menu options over core sets.

ACS appreciates the opportunity to offer these comments and looks forward to continuing to work with CMS and ONC in order to provide additional feedback on the EHR Incentive Program. If you have any questions about our comments, please contact Jill Sage, Manager of Quality Affairs in the Division of Advocacy and Health Policy. She can be reached at jsage@facs.org or 202-672-1507.

Sincerely,

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Executive Director, ACS

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