American College of Physicians
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June 20, 2014

The Honorable Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Re: 45 CFR Part 170; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition

Attention: CMS-0052-P

Dear Ms. Tavenner:

On behalf of the American College of Physicians, I am writing to share our views on the proposed rule to allow certified electronic health record technology (CEHRT) requirement flexibility, as well as formally extending the deadline for reporting Stage 2 of Meaningful Use (MU). ACP is the largest physician specialty society and second-largest physician membership organization in the United States. ACP represents 137,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults.

ACP applauds ONC and CMS, as well as the Health IT Policy Committee and Standards Committee for their diligence and hard work in developing the EHR Incentive Program, including the acknowledgment of a very aggressive timeline combined with overly ambitious objectives that, if left unchanged, would unnecessarily limit the success of the entire EHR Incentive program. As you work to transform this proposed rule into ambitious yet broadly achievable deadlines and requirements, we urge you to keep in mind the original guiding principles of the program – to position physicians and other healthcare providers to deliver excellent, patient-centered care focused on improving clinical outcomes.

Overall, we support this effort to address the realities that physicians are facing in 2014 and this shows that CMS/ONC is listening. MU appears to be on shaky ground, and if the percentage of physicians who are successful with Stage 2 is really low, the chances of program failure may be much higher. While hospitals may not have a choice, most internists do; and if the options are to continue participation in a program that is seen as burdensome and not providing benefit, or to accept a penalty, more physicians would choose to accept the penalty and/or cut back on Medicare patients.

While the changes outlined in this NPRM may appear beneficial, the timing is problematic at best. It would be imprudent for the College to recommend to members that they take action based upon a

proposed rule. By the time the rule is final, it will be too late to pick an option, revise systems to support that option, revise workflows, train staff, and begin to safely care for patients under that option. More importantly, the assumption that EPs will be able to report using 2011 or mixed software is fundamentally flawed. All EPs absolutely must be in full and safe operation using 2014 systems by January 1st, 2015. This means that the fourth quarter of 2014 is not available to them for attestation. They will be spending the last quarter getting their 2014 system running. Even if all providers get implemented with the 2014 edition before Jan 1, 2015, it is not plausible to expect that they will have the necessary workflows and practice changes necessary to be successful for a 365-day reporting period. This NPRM places many EPs in a bind. Either they must forgo a 2014 incentive to spend the time getting ready for 2015, or the can try to attest in 2014 knowing that they will not be ready for 2015 in time. **Therefore, ACP strongly recommends that CMS recognize this problem now, and insert into this NPRM what will be necessary for 2015 – 90 day reporting periods.**

Limiting reporting to calendar year quarters rather than 90-day periods is unnecessarily limiting flexibility, particularly for providers trying to be proactive and diligent. While "flexibility" is being offered to those who are not yet ready for Stage 2 or are not yet equipped with 2014 CEHRT, no help is offered to these diligent early adopters. The quarter system makes it almost impossible to attest successfully, as denominators can change in a few days based on patient mix, scheduling, whether patients are resistant to registering or looking at a portal, etc. At least if there is a flexible 90-day window, there are more chances for the stars to align properly to succeed on all measures. The pioneers should not be penalized. **ACP urges CMS to change the 2014 reporting periods from calendar quarters to any consecutive 90 days for all EPs.**

Based on the Stage 2 NPRM and comments, CMS had announced there would be no delay in starting Stage 3. However, the announcement made December 13, 2013 agreed with ACP's recommendation to declare Stage 3 as starting no earlier than 2017. This NPRM announces this change as if a delay were not already established. This NPRM actually backtracks on extending Stage 2 for all participants. **The work of Stage 2 is so complicated that ACP proposed that the timing for Stage 3 should be redrafted to say that all EPs will spend a full three years in Stage 2 prior to being required to move to Stage 3.**

This NPRM will have the unintended consequence of reducing the number of Stage 2 attesters. This proposed flexibility is very welcome for those providers waiting to be upgraded to 2014 CEHRT, or who were recently upgraded and still are working through the process changes. However, it unfairly penalizes those providers who are otherwise ready to attest under the Stage 2 rules – but now find themselves unable to do so because of lack of a "network effect." Thus, if a practice is fully ready for Stage 2, but is alone in their community – they cannot pass the Transitions of Care (ToC) measure, numerator 2, as there may be no other locations in their community that are in the same situation regarding 2014 CEHRT and have adopted the direct protocol. We hope that these practices could take advantage of this proposed flexibility – as they can honestly attest that they are not fully implemented. Otherwise, practices that are fully implemented, but through no fault of their own are unable to electronically communicate with colleagues have no recourse, and will thus fail MU. **ACP believes that lack of ability to generate a trust certificate required to use the CMS Randomizer, or lack of sufficient number of ToC partners should be valid criteria for inclusion in the CMS final definition of "not fully implemented."** These physicians do not want to simply avoid a penalty. They have done the hard work, and they want their incentive payment. For those who have tried to attest to Stage 2 but failed, it seems almost punitive to have to revert back to stage 1 measures for 90 days and then move back to Stage 2 levels of performance.

Further comments on specific elements of the proposed rule can be found in the table on the following pages.

Sincerely yours,

Peter Basch, MD, FACP
Chair, Medical Informatics Committee
American College of Physicians

CMS/ONC Proposed Rulemaking allowing CEHRT Flexibility and Extending Stage 2	ACP Comments
The Three Changes/Options for the use of CEHRT editions: a) Using 2011 Edition CEHRT Only • All EPs that use only 2011 Edition CEHRT for their EHR reporting period in 2014 must meet MU objectives and associated measured for Stage 1 that were applicable for the 2013 payment year (2013 Stage 1 objectives and measures). • Providers who choose this option must attest that they are unable to fully implement 2014 CEHRT Edition because of issues related to availability delays. b) Using a Combination of 2011 and 2014 Edition CEHRT • All EPs may choose to meet either the 2013 or 2014 Stage 1 measures or objectives. • or if they are scheduled to begin Stage 2 in 2014, they may choose to meet the Stage 2 objectives and associated measures • Providers who choose this option must attest that they are unable to fully implement 2014 CEHRT Edition because of issues related to availability delays. c) Using 2014 Edition CEHRT for 2014 Stage 1 Objectives and Measures in 2014 for Providers Scheduled to begin Stage 2 • Providers scheduled to begin Stage 2 for the 2014 EHR reporting period but are unable to due to delays in 2014 Edition CEHRT availability would have the option of using 2014 Edition CEHRT to attest to the 2014 Stage 1 objectives and measures for the 2014 EHR reporting period. • Providers who choose this option must attest that they are unable to fully implement 2014 CEHRT Edition because of issues related to availability delays.	ACP supports options a), b), and c), with the following modifications: CMS should change the requirement to report by quarter. The reporting period should be any 90-day period. See the explanation in the above letter. If the "associated measures" means eCQMs, it may be problematic to require earlier versions of the measures. 2014 updates address many of the errors and inconsistencies in prior versions. EPs should be able to use the most updated versions if they are able. Option a) ACP particularly supports the ability for EPs to remain on a 2011 edition EHR, given the expense and difficulty of upgrading for smaller and struggling practices. Option b) seems appealing, but it is not clear as to how providers can adequately report on measures, as for those without access to report writers, they are 100% reliant upon what comes with the product. The Final Rule should clarify reporting and further clarify EXACTLY what documentation is need for the required assertion that EPs were unable to fully implement 2014 CEHRT. E.g., (a) Is a letter from the vendor sufficient? (b) If a consultant is backlogged and unable to assist is the EP required to look for other consultant before being able to attest? We are concerned that CMS will suggest one set of requirements in the rule, and one year later, its auditors will look for something different when they examine practice documentation . ACP believes that the test for "fully implement" should include inability to find sufficient exchange partners.

CMS/ONC Proposed Rulemaking allowing CEHRT Flexibility and Extending Stage 2	ACP Comments
Medicaid Incentive Payment A provider would not be able to qualify for a Medicaid incentive payment for 2014 for adopting, implementing, or upgrading to 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT.	ACP is concerned with this proposed requirement that Medicaid-eligible EPs must adopt, implement, or upgrade 2014 CEHRT. Just as with the Medicare program, many Medicaid practices are struggling and unable to implement 2014 CEHRT this year. Also, this proposal seems discordant with the options available to Medicare EPs. We could support this proposal, so long as the reporting requirement is attestation only and that the audit requirements are not more strenuous. For example documentation of a plan to upgrade from older technology should be sufficient.
2014 Edition CEHRT Mandated Utilization In 2015, all providers are required to have 2014 Edition CEHRT in order to successfully demonstrate meaningful use	ACP supports this, with the amendments made in the above letter– 2015 should also allow for 90-day attestations, as new technology adoptions will occur towards the end of CY 2014, and very few EPs will have the process / workflow changes fully implemented on Jan 1, 2015.
Extension of Stage 2 Meaningful Use Providers that were scheduled to begin Stage 2 in 2014 that instead meet the Stage 1 criteria in 2014 will be required to begin Stage 2 in 2015. In 2015, all providers, except those in their first year of demonstrating meaningful use, are required to have a full year EHR reporting period.	ACP supports this, with the amendments made in the above letter.
Stage 3 Start Delay Stage 3 would begin in CY 2017 for EPs and FY 2017 for eligible hospitals and CAHs that first became meaningful users in 2011 or 2012.	This delay of the start of Stage 3 to 2017 was announced previously in December 2013. This NPRM actually backtracks, as it was previously implied that Stage 2 would be a 3 year stage – due to the complexities of workflow and the hoped for progression to advanced clinical processes. All EPs should spend three full years in Stage 2 before moving to Stage 3.
Clinical Quality Measure Submission in 2014 1. If a provider elects to use only 2011 Edition CEHRT for its EHR reporting period in 2014, the provider would be required to report CQMs by attestation: a. EPs would report from a set of 44 measures and	ACP supports these options, assuming that the process to receive eCQMs is fully operational in time for reporting. Otherwise, EPs should be able to submit using prior attestation methodology. We are also concerned that EPs who have implemented 2014 CEHRT may find that, despite

CMS/ONC Proposed Rulemaking allowing CEHRT Flexibility and Extending Stage 2	ACP Comments
according to the reporting criteria finalized in Stage 1 final rule (the reporting period would be any continuous 90 days within CY 2014 for EPS demonstrating MU for the first time or a 3-month CY quarter for EPs that have previously demonstrated MU. 2. If a provider elects to use a combination of 2011 Edition and 2014 Edition CEHRT and chooses to attest to the 2013 Stage 1 objectives and measures for its EHR reporting period in 2014: a. Provider reports CQMs by attestation using the same measure sets and reporting criteria as those using only 2011 Edition CEHRT for their EHR reporting periods in 2014. 3. If a provider elects to use a combination of 2011 Edition and 2014 Edition CEHRT and chooses to attest to the 2014 Stage 1 or Stage 2 objectives and measures: a. Provider submits CQMs in accordance with the requirements and policies established for clinical quality measure reporting for 2014 in Stage 2 final rule and subsequent rulemaking 4. If a provider elects to use only 2014 Edition CEHRT for the entire duration of the reporting period in 2014 for either Stage 1 or 2: a. Provider submits CQMs in accordance with the requirements and policies established for 2014	their best efforts, their system is unable to collect and report as required.