



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

May 26, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled, "Stage 3; 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications" as published in the March 30, 2015 *Federal Register*.

The AAFP appreciates that the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator (ONC) for Health Information Technology seek public comment on the Stage 3 criteria in order to improve healthcare and the way electronic health information is shared. The AAFP continues to encourage our members to adopt electronic health records in order to provide better patient care. We acknowledge that the proposed rule is designed to provide additional flexibility, to simplify the program, and to drive interoperability among electronic health records. We share the belief that these taken together will improve care. However, our longstanding concerns with the increasingly challenging Meaningful Use requirements continue and we, therefore, urge the agency to revise the approach to the Meaningful Use program so that more physicians are able to achieve these objectives.

Since the initiation of the Meaningful Use program, there have been fundamental changes in the health care landscape. Secretary Burwell announced plans to move aggressively toward value-based payment and Congress passed the *Medicare Access and CHIP Reauthorization Act (MACRA)*, which also moves the country forward to value-based payment. The transition to value-based payment will require fundamental changes within the health care system. We have grave concern that the timing of Meaningful Use Stage 3, in relation to the Merit Based Payment System (MIPS) and other *MACRA* changes, will compete and potentially interfere with practices' transformation to value-based payment. Current health IT does not yet have the interoperability required to support value-based payment nor the functionality to be efficient and effective in this new paradigm. We strongly urge CMS to delay Meaningful Use Stage 3 until:

- The regulations of MIPS are known and implemented
 - Meaningful Use Stage 3 requirements are completely harmonized with the requirements of MIPS;
- and

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- The certified health IT has the needed interoperability and functionality to support the value-based payment needs of practices.

The AAFP strongly supports the CMS expectation that Stage 3 is the final stage of the Meaningful Use program. We recognize the laudable goal of moving all participants in the EHR Incentive Programs to a single stage of Meaningful Use in 2018 but remain concerned with the limited timeframe and current challenges impeding successful participation in Stage 1 and Stage 2.

Directly based on these concerns, the AAFP opposes the agency's proposal to remove the 90-day EHR reporting period currently available to eligible professionals, eligible hospitals, and critical access hospitals attempting to demonstrate meaningful use for the first time and instead require them to report a full calendar year reporting period after 2015. This proposal places an enormous burden on all new adopters of EHRs but also those struggling to modernize their practices and meaningfully use an EHR. We are concerned that it remains unclear whether CMS could start the full-year reporting proposal when certified electronic health record technology (CEHRT) becomes available to the practice or would CMS wait until the next year and not subject the practice to another year of penalties. As a solution to these scenarios, the AAFP suggests CMS consider a required attestation reporting period for 90-days with the expectation that the practices will continue to utilize highly functioning EHRs that successfully attested within the three months.

CMS recognizes in this proposed rule that many physicians struggle to meet Meaningful Use objectives by including an exception for Medicaid eligible professionals and eligible hospitals demonstrating meaningful use for the first time in 2017 by allowing them to continue to use a 90-day reporting period. We support this course and urge CMS to extend this exception to physicians.

Though we maintain that CMS should offer staged approaches for new and struggling adopters, we also support the CMS proposal to allow practices the choice to bypass Stages 1 and 2 and begin the program at Stage 3. We recognize that some practices have the resources and interest to adopt the final Stage 3. However, the AAFP reiterates the concern that the elimination of the 90-day reporting period creates a significant barrier to successful participation. The AAFP encourages CMS to finalize policy that allows physicians to progress through the Stages as desired but also have the option to jump forward to Stage 3 in 2017 and beyond.

The AAFP maintains deep concern with the "all or nothing" nature of the Meaningful Use program. As discussed in our April 6 [letter](#) to CMS with increasing concerns with Meaningful Use audits, many family physicians implemented and use EHRs in the full spirit of the Meaningful Use program. They, therefore, have a reasonable expectation that the Meaningful Use financial subsidy would help offset the implementation costs and associated initial decrease in practice productivity. The proposed rule discusses and then declines to follow recommendations made by stakeholders for allowing recourse, exceptions, and leniencies for a physician or practice encountering difficulties to receive a partial incentive payment or avoid all or some of the Meaningful Use penalty under certain circumstances.

The AAFP concurs with the proposal to remove redundant, duplicative, or "topped out" measures or measures CMS feels are no longer useful in gauging performance. Family physicians disproportionately more than other specialties are able to report on more measures since they treat all ages, conditions, and organ systems. CMS should collect only the information that is meaningful toward improving patient care

and avoid requiring busy work and we consider the proposal a step in that direction. We are currently undertaking a study to evaluate each meaningful use criterion of benefit to patient care and burden. We plan to have results to share in late summer 2015. As part of this study, we have recruited practicing physicians and industrial engineers to break down the high-level requirements into tasks that must be performed by the eligible professional. This will show the workload hidden in the high-level descriptions of the required criteria.

To better align the Medicare and Medicaid EHR Incentive Programs and other CMS quality reporting programs, such as the Physician Quality Reporting System and Hospital Inpatient Quality Reporting Program, CMS proposes to address clinical quality measure reporting requirements for 2017 and subsequent years in the Medicare Physician Fee Schedule and Hospital Inpatient Prospective Payment Systems. The AAFP supports harmonization of quality measures across all programs, all payers, and all settings and we therefore support this proposal.

The AAFP understands that because multiple technological and clinical care standard changes associated with EHR technology may occur, the proposal rule references the potential need to consider further changes to the objectives and measures of Meaningful Use and address them as needed in future rulemaking. However, the proposed rule also states that Stage 3 is expected to be the last stage. For EHR purchasing purposes, practices likely will therefore want to adopt certified EHR technology that meets criteria specified in the final rule CMS will produce. EHR vendors will likely not make future changes required by CMS and thus the purchased technology would be outdated by virtue of the regulation alone. The practice would likely then incur a penalty for not successfully meeting future and unknown Meaningful Use criteria unless they purchase expensive and time-consuming upgrades. The AAFP urges CMS to recognize the need for several years of stability so that medical practices, hospitals, EHR vendors, and other stakeholders have time to catch up and meet final Stage 3 criteria. In short, Stage 3 of Meaningful Use should represent the final requirements of this program until Medicare and our health care system fully transition to a value-based payment system as envisioned by the *MACRA* law now in place.

In the proposed rule's discussion of electronic versus paper-based objectives and measures, CMS states that paper-based fulfillment of Meaningful Use objectives do not count in Stage 3 but that physicians are expected to support them if desired by the patient. The AAFP agrees with CMS that some patients may prefer to receive a paper version of their clinical summary and that this approach is favorable since it improves the patients' understanding of their conditions and adherence to the recommended treatment. To address these situations, the AAFP believes that the eligible professional should have the option for those unique patients to be excluded from the denominator in reporting situations.

In the spirit of adding flexibility, CMS proposes that successful participation in Meaningful Use would allow providers to attest to the results for the numerators and denominators of all measures associated with an objective but that the physician would only need to meet the thresholds for two of the three associated measures. While the AAFP recognizes this may be desirable for some practices as a way to avoid penalties, the proposal essentially creates more work for the practice by promoting the over-reporting of quality measures. The AAFP encourages CMS to make this optional. Physicians are already overburdened with quality reporting programs and CMS should collect only the data that is needed to improve clinical and patient care. Promoting an atmosphere of optional, over-reporting only underscores these lingering challenges medical practices experience daily with quality reporting.

CMS unfortunately did not propose to change the Meaningful Use penalties despite recognizing the current challenges associated with Stages 1 and 2. We urge the agency to reconsider this and significantly expand and utilize HHS' discretionary authority to make case-by-case exemptions for significant hardships. As part of this, we encourage CMS to review the growing list of Meaningful Use appeals as a basis for creating new hardship criteria and understanding the significant investments that practices make yet are not recouping.

CMS proposes that manual abstraction of data from an EHR would not be for the purposes of meeting data capture using a certified EHR but that electronic information that is interfaced or electronically transmitted from a non-certified EHR such as lab information systems, automated blood pressure cuffs, and electronic scales, into the certified EHR, would satisfy the "capture" requirement as long as data is visible to the physician in the EHR. The AAFP supports this proposal and encourages CMS to further specify which technology meets this requirement. In the absence of such specificity, the AAFP is concerned that EHR vendors and auditors may use their own discretion and demand that practices either upgrade their software or produce proof of the EHR documentation.

CMS proposes that a patient seen through telehealth as a patient "seen by the EP" would count toward Meaningful Use and that telehealth may include commonly known telemedicine as well as telepsychiatry, telenursing, and other diverse forms of technology-assisted health care. However, the agency specifies that in cases where the EP and the patient do not have a real time physical or telehealth encounter, but the EP renders a consultative service for the patient, such as reading an EKG, virtual visits, or asynchronous telehealth, the EP may choose whether to include the patient in the denominator as "seen by the EP." Overall the AAFP concurs with this approach yet urges CMS to provide greater clarity on what is and is not telehealth for Meaningful Use purposes. In the absence of CMS specificity, the AAFP is concerned that EHR vendors and auditors may use their own discretion and cause needless variation in functionalities and documentation processes.

CMS proposes as part of the objectives concerning "Coordination of Care through Patient Engagement" and the "Patient Electronic Access," to include patient-authorized representatives in the numerators and encourages providers to provide access to health information in accordance with all applicable laws. The AAFP supports this approach and agrees with CMS that patient-authorized representatives would have the patient's best interests at heart and will act to protect the patient.

The proposed rule states that the agency does not believe it would be appropriate for eligible professionals and hospitals to charge patients a fee for accessing their information using an application programming interfaces (APIs). The AAFP concurs but also strongly encourages CMS to specify that vendors should likewise not charge physicians for API functionality. The proposed rule seeks comment on whether the API option should be required or optional for providers. We believe that this should be optional since using APIs is a new requirement and actual use of qualifying APIs has not been fully implemented.

For the proposed measure 1, CMS suggests that more than 25 percent of all unique patients seen by the physician access their health information through the use of an ONC-certified API that can be used by third-party applications or devices. The AAFP strongly objects to this high threshold since we believe experience suggests 25 percent is not achievable via the API. Given that APIs are not currently available and there are no patient-facing applications available using APIs, it seems overly ambitious to require such a high threshold. In addition, we have seen the challenge of patient adoption of technology (e.g., the adoption of secure messaging and patient portals) requiring reduction in thresholds for Stage 2. CMS should follow

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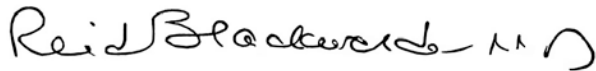
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closely the adoption of APIs by CEHRT and the availability of patient-facing applications and adjust the thresholds for this requirement accordingly.

CMS seeks comment on whether the proposed measure 1 should have a denominator limited to patients with whom the provider has multiple encounters, such as unique patients seen by the provider two or more times during the EHR reporting period. CMS seeks comment on whether this measure should be divided into two distinct measures. The AAFP does not believe the measure should be divided and instead encourages CMS to maintain it as a single measure.

We appreciate the opportunity to provide these comments. Please contact Steven E. Waldren, MD, MS, Director, Alliance for eHealth Innovation at 800-274-2237, extension 4100 or swaldren@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Reid B. Blackwelder, MD, FFAFP". The signature is written in a cursive, slightly slanted style.

Reid B. Blackwelder, MD, FFAFP
Board Chair