TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

June 15, 2015

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

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program — Modifications to Meaningful Use in 2015 Through 2017

Dear Acting Administrator Slavitt,

The Texas Medical Association (TMA) is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: "Physicians Caring for Texans." TMA's diverse physician members practice in all fields of medical specialization.

On behalf of our 48,000+ members, TMA appreciates this opportunity to offer comments on the proposed rules relating to Medicare and Medicaid Programs; Electronic Health Record Incentive Program — Modifications to Meaningful Use in 2015 Through 2017, as published in the *Federal Register* on April 15, 2015.

Recommendations

II.B.1.b.(1) Stages of Meaningful Use

Comment: TMA agrees with CMS' approach to allow physicians to attest to a modified Stage 2 set of criteria for 2015 through 2017. As CMS contemplates the need for allowing the option of attesting to Stage 3 in 2017, TMA believes that it is likely that most will still select the Stage 2 option for attestation, and that it would make more sense to only have one available attestation portal to reduce program complexity and confusion.

II.B.1.b.(2)(b) 90-Day EHR Reporting Period for All Providers in 2015

Comment: TMA appreciates CMS' recognition of the upheaval industry changes cause to physicians and other providers, and is grateful for the 90-day reporting period in 2015.

Comment: TMA recommends that CMS consider a 90-day reporting period in subsequent years for physicians transitioning to a new or significantly upgraded EHR.

Rationale: Safe and effective data migration and transition to a new EHR are enormous undertakings for a practice of any size. To allow eligible professionals (EPs) a 90-day reporting period when they change or significantly upgrade their EHR systems, such as moving to the ONC 2015 CEHRT in preparation for 2018, would relieve the reporting burden and stress.

II.B.1.c.(1) Considerations in Defining Meaningful Use

Comment: TMA agrees with CMS' proposed approach to removing reporting on meaningful use measures that are redundant, duplicative, or topped out. Additionally, TMA encourages CMS to consider allowing specialty societies to provide input on exclusions and/or specific input on what should or should not be required for a respective specialty. For example, requiring a pediatric practice to meet measures designed for an adult patient population is not reasonable and may result in unintended consequences or safety risks.

Comment: TMA encourages CMS to consider a "cumulative" approach to the remaining measures that would allow a physician who may not quite meet one measure to have the opportunity to make up for a minor shortfall by exceeding other measure thresholds.

Rationale: The current structure often does not consider physicians' efforts to meet meaningful use measures. For example, a physician who records 79 percent of his or her medication orders via computerized provider order entry fails the proposed measure's 80-percent threshold — even in situations where the physician exceeds one or both of the other proposed measures relating to laboratory orders or diagnostic imaging orders. TMA is concerned that the lack of flexibility in meeting certain measures discourages meaningful use program participation, and penalizes physicians that fall just short of a given threshold, despite significant investment of time and effort.

II.B.1.c.(2)(c) Changes to Patient Engagement Requirements 2015 Through 2017

Comment: TMA supports removing the 5-percent threshold from meaningful use Stage 2 and replacing it with "at least one patient seen during the reporting period who views, downloads, or transmits his or her health information to a third party." TMA agrees with CMS that physicians should have this functionality enabled, but should not be required by regulations to force patients to use it — particularly when certain patients are not amenable to utilizing such methods. TMA strongly encourages CMS not to increase this requirement in the future beyond the one-person capability demonstration.

Rationale: Some patients have complained to physicians that they do not like pressure from the practice staff to access their health information and communicate with the staff online. Many elderly patients have much less desire to view, download, and transmit information electronically.

TMA believes that in the future, if CMS wants patients to behave a certain way, a more appropriate approach would be to incentivize patients, not penalize physicians for patient behavior. Setting requirements on physicians that negatively impact patient satisfaction and the patient-physician communication process clearly is not desirable. Patients and physicians should be free to communicate in ways that suit patient needs rather than being required to meet arbitrary government standards.

Comment: TMA agrees with CMS that secure electronic messaging should be a demonstration of capability only.

Comment: TMA believes that CMS should not require patient metrics around secure messaging in future rulemaking.

Rationale: When communicating with their physician, patients' preferences should be honored. Physicians should not be required by regulation to force patients to set up accounts for secure messaging to meet a metric that does not make sense or is not desirable for all patients.

II.B.2.b. Clinical Decision Support

Comment: TMA recommends that the measure requiring the implementation of five clinical decision support (CDS) interventions be removed.

If CMS retains the CDS interventions measure, TMA encourages CMS not to tie the CDS interventions to clinical quality measures (CQMs). This would provide freedom for physicians to choose CDS tools that help their practice, and to implement CQMs in a way that is more meaningful to them.

Rationale: TMA is not disputing the value of CDS interventions, but does take issue with how it must be presented to the EP through the CEHRT. This obligation requires significant extra programming of the CEHRT and comes at significant cost to the end user. The concept that CDS must be tied to CQMs further complicates the process. It is difficult for EHR vendors to calibrate their software for CDS considering the ranges of opportunities by specialty. This is an example of information technology becoming so general that it is ineffective. Some EHRs require multiple clicks to document an obvious course of action. Multiple clicks contribute nothing to patient care and actually lessen the time the physician has with the patient. Instead, TMA encourages CMS to delegate CDS to specialty societies and not tie it to the meaningful use program.

II.B.2.d. Electronic Prescribing

Comment: An exclusion should be allowed for patients who desire a typed paper prescription instead of an e-prescription.

Rationale: It is important for CMS to understand that not all patients want their prescriptions sent electronically. Physicians should be allowed to honor patient preference without fear of penalty.

As the proposed requirements are written, the e-prescribing measure assumes that most patients are comfortable with receiving completely electronic prescriptions. This measure does not allow exclusions for typed paper prescriptions that the patient may request. Physicians have reported to us that patients prefer paper for a variety of reasons, such as:

- They are unsure which pharmacy they will stop at on the way home from their visit and don't want to have the prescription sent to the wrong pharmacy. Most EMR software requires the physician to cancel a prescription if it is to be sent to a new pharmacy rather than having a mechanism where pharmacies can transfer prescriptions without physician involvement.
- They want to shop for the least expensive medication.
- They have medications that they wish to keep private and do not trust having their information exchanged electronically.

TMA believes that physicians should be free to respect and honor patient preference, and the 80-percent requirement does not provide sufficient allowance for patient preferences in many practices. Therefore, the TMA recommends that exclusions be allowed within this measure when a patient specifically requests a paper prescription.

II.B.2.e. Summary of Care

Comment: TMA believes that CMS should consider only requiring a demonstration of capability for the EHR to create and send a summary of care document for transitions of care.

Rationale: TMA believes that the measure places too much reliance on EHR technology in that it requires the EHR to both generate and send the summary. We believe that the physician should be able to use EHR technology to generate the summary of care, but then the physician should be allowed to transmit that summary using whatever method works best for the practice. In some cases that might mean that the physician sends the summaries to a health information exchange (HIE) or other entity so that they can be available for others, if desired. This would encourage the use of HIEs, which is a desirable goal.

Comment: TMA recommends that the labs and vital signs for the patient only include the last values recorded for each lab and vital sign.

Rationale: It is unsafe and may be overwhelming to the provider receiving the summary of care to have all values listed. After a hospital stay, for example, it is not uncommon to see 50 or more pages of information when every value taken is included.

II.B.2.e. Patient Specific Education

Comment: The need for patient education should be based on clinical documentation rather than limiting it to education needs derived from the problem list, medication list, or labs. An example could be secondhand smoke. If there is a smoker in the house, secondhand smoke education is very valuable, but there is no lab, medication, or problem list entry that would trigger it. (It is generally agreed that the problem list should not be cluttered with this type of issue.) Physicians should receive credit for providing patient-specific education when the EHR documentation triggers the need for education in addition to problem lists, medication lists and labs.

II.B.2.h. Patient Electronic Access

Comment: TMA recommends that the labs and vital signs for the patient only include the last values recorded.

Rationale: It is unsafe and may be overwhelming for patients to have values listed that are no longer relevant. After a hospital stay, for example, patients might receive dozens or hundreds of the same lab result (e.g., hematocrits in a GI bleeding case) that are no longer relevant to their care. CMS needs to consider the readability of information provided to patients; sending all labs and vital signs significantly decreases the ability of the patient to understand their information.

Comment: TMA recommends that CMS permit physicians to count transmission of CCDAs to patient personal health records (PHR) in meeting the patient electronic access measures. If the patient has his or her own PHR, the physician should get credit for sending the information to the patient without having to prove the patient received or opened it. **Patients want consolidated portals and personal health records.** When CMS incentivizes physicians to have their own separate portal to meet metrics, physicians are being forced to go against patient wishes. Patient preference must be honored if we expect to increase their engagement.

II.B.2.j. Public Health and Clinical Data Registry Reporting

Comment: TMA recommends that CMS allow credit for the public health reporting measures if a physician is participating in an ACO or ACO-type organization.

Rationale: ACOs and ACO-type organizations support value-based care, and this should be considered equivalent to a public health registry.

Comment: TMA agrees with the active engagement options proposed by CMS. TMA further believes that physicians should have the option to submit to public health registries through their local HIEs. This improves the efficiency of technology by allowing physicians to submit once to the HIE, and permit the HIE to submit to participating registries on behalf of the physician. The measure as written encourages point-to-point connections between EHRs and registries, which are much less efficient than HIE reporting.

II.D.5. Hospital-Based Eligible Professionals

Comment: TMA believes that place of service code 22 (POS 22) should be included in the hospital-based definition, even though it is considered outpatient. TMA further believes that CMS should retroactively make this correction, and refund physicians who were penalized because of this issue.

Rationale: Physicians who use POS 22 typically are using the hospital-based EHR during the patient observation period, and should not be penalized.

TMA continues to work with Texas physicians to help them understand the complexities of the meaningful use program and continues to field numerous calls from physicians attempting to comply with the requirements. We appreciate the opportunity to share the experiences of our members.

Thank you for the opportunity to comment on the EHR incentive program proposed modifications for 2015 through 2017. Should you have additional questions or need any further information, please do not hesitate to contact Shannon Vogel at TMA at (512) 370-1411 or shannon.vogel@texmed.org.

Sincerely,

Matthew M. Murray, MD
Chair, Ad hoc Committee on Health Information Technology
Texas Medical Association