May 7, 2012

Ms. Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0044-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2 (CMS-0044-P)

Dear Acting Administrator Tavenner,

On behalf of the undersigned organizations, we appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) proposed rule: *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2*[1] for the Stage 2 of the meaningful use objectives and measures that must be met by eligible professionals (EPs) to ensure receipt of the financial incentives and avoid the penalties specified by the American Recovery and Reinvestment Act[2] (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 are meaningful users of an EHR by 2015 will face reductions, starting at one percent, in their Medicare payments.

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 meaningful use of EHR technology to implement such changes. Our comments on issues of interest to our organizations are directed toward the proposed rule as it applies to EPs unless otherwise noted. Our comments are presented in the order in which they appear in the proposed rule.

Definitions across the Medicare Fee for Service, Medicare Advantage, and Medicaid Programs

Uniform Definitions

CMS proposes to clarify that providers who are demonstrating meaningful use for the first time will have an EHR reporting period of 90 days regardless of payment year. While we have always understood this to be the case, we appreciate this clarification.

[1] Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Stage 2, 77 FR 13698 (proposed March 7, 2012).
[2] American Recovery and Reinvestment Act of 2009, Pub. L. 111-5.

State Flexibility on Meaningful Use:

CMS proposes to offer States the same level of flexibility as was accorded under Stage 1 for certain measures. More specifically, CMS would allow States to specify the means of transmission of data for the public health measures as long as it does not require EHR functionality beyond what is included in the Office of the National Coordinator (ONC) EHR certification criteria as finalized for Stage 2. CMS would also provide State flexibility with respect to the measure to generate lists of specific conditions to use for quality improvement, reduction of disparities, research or outreach. This flexibility will apply regardless of whether the measure has been moved to the core set or left in the menu set. We support this proposed flexibility.

EPs Practicing in Multiple Locations and Practices:

For Stage 2, CMS proposes to continue its policy that in order to be an EHR meaningful user, an EP must have 50 percent or more of his or her outpatient encounters during the EHR reporting period at a practice or location equipped with certified EHR technology (CEHRT). CMS also proposes to no longer allow an EP to create a record of an encounter without using CEHRT at a practice or location and then later inputting the information into CEHRT that exists in a different practice or location. This practice is currently allowed as part of Stage 1. We believe that this new proposal will create the potential for EPs who have made investments in CEHRT to be penalized for circumstances outside of their control. Additionally, this creates the potential for unnecessary and arbitrary inconsistency in eligibility between performance periods. The undersigned organizations also seek further clarification on how exactly CMS will calculate the 50 percent requirement and questions the significance of the threshold of 50 percent as it appears to be an arbitrary number. We believe that the task of identifying "meaningful users" of CEHRT is better accomplished by focusing on the numerators of the core, menu, and clinical quality measures.

Additionally, the undersigned organizations are greatly concerned that CMS is proposing to require EPs to apply the meaningful use measures to their entire patient population including non-Medicare/Medicaid, while only providing incentives based on an EP's Medicare or Medicaid patients. This is unfair for EPs, especially those who may have more private payer patients than Medicare or Medicaid. Additionally, CMS' intention to expand the EHR Incentive Program to all payers is not streamlined with other quality reporting programs such as the Electronic Prescribing Incentive Program which is only applicable for an EP's Medicare Part B patients. It also raises serious privacy concerns since private payer patients are not expecting to have their personal information disclosed to the federal government just so providers can meet the requirements imposed on them through the Medicare and Medicaid EHR Incentive Program.

Objectives and Measures Carried Over (Modified or Unmodified) from Stage 1 Core Set to Stage 2 Core Set

The undersigned organizations are concerned that the proposed thresholds being increased from 10 percent to 50 percent, from 30 percent to 60 percent, or from 50 percent to 80 percent (as applicable), are far too high for Stage 2. It appears rather arbitrary to us as to why CMS has specifically chosen these numbers. Without a thorough analysis of Stage 1, the higher threshold requirements do not make sense. We would advise CMS to allow the program to mature and to do a thorough analysis on Stage 1 using a large amount of data from various physician specialties before making threshold determinations. We believe that only after a Stage 1 measure is appropriately analyzed, may the threshold amount be increased and then by no more than 10 percent for Stage 2.

Electronic Prescribing (eRx):

The proposed threshold for requiring more than 65 percent is high, especially for surgical specialists who commonly write prescriptions where electronic transmission is often not permissible (that is, for controlled substances). Unless new eRx technology can allow for the electronic prescribing of controlled substances under a previously published Drug Enforcement Administration interim final rule, this criterion would require such specialists to simultaneously use dual prescribing systems, electronic and non-electronic, for a large proportion of their patients, creating work flow disruptions and possibly confusing affected patients.

Additionally, CMS seeks comment on whether, if controlled substances can be electronically prescribed, CMS should create a separate measure for it or include it in the current eRx measure. First, regardless of whether e-prescribing controlled substances is included in the current measure or addressed in a separate measure, we believe that e-prescribing controlled substances should not be included in the denominator unless the EP has voluntarily decided to meet the separate Drug Enforcement Agency's (DEA) requirements for prescribing controlled substances electronically and is able to incorporate this functionality into the EHR. Because of the significance of the DEA requirements, we do not believe that physicians should be mandated to electronically prescribe controlled substance because of the additional resources needed to incorporate this functionality and the burden required to do this created by the DEA regulations. If, however, by 2014 significant progress in creating products that allow the electronic prescribing of controlled substances is made, and if these products become readily available, and if an EP elects to incorporate controlled substance e-prescribing functionality into his or her EHR, this would be sufficient for the inclusion of controlled substances into the Stage 2 measure for eRx. Given that eRx is already a core measure that is difficult for EPs such as surgeons to meet, including controlled substances into this measure would allow more EPs to successfully meet this core requirement. Thus, we do not feel that it would be necessary to create additional measures that would include controlled substances in the denominator.

Furthermore, although we are appreciative of CMS' proposed exclusions for this measure, we urge CMS to consider expanding the exclusion for EPs who write fewer than 100 prescriptions during an EHR reporting period to apply to EPs who write fewer than 200 prescriptions during the EHR reporting period in order to keep it consistent with the Medicare eRx Incentive program hardship exemption. That exemption allows physicians who prescribe fewer than 100

prescriptions during a *6 month* eRx reporting period to be exempt from receiving the eRx penalty. Since the EHR reporting period is one full year and not six months, we would ask CMS to consider increasing the prescription threshold. Although we are aware that the Medicare eRx Incentive Program is not yet proposed to go beyond 2014, and the reporting period for the 2014 payment adjustment will have already occurred for the eRx program, we believe that keeping similar and consistent requirements between programs will allow more physicians to navigate and successfully meet this requirement. We also request CMS to consider those EPs who have met the requirements of being a successful electronic prescriber for the Medicare eRx Incentive Program in 2014, as having successfully met the eRx measure for the Medicare EHR Incentive Program. We urge CMS to have consistent requirements, to the extent possible, as maintaining consistency will also help to reduce the administrative burden of complying with these program requirements.

Clinical-Decision Support:

We are supportive of CMS' decision to allow a provider to use his or her discretion to determine which clinical decision support interventions would address high priority conditions. However, we recommend that their proposal to require that the intervention be related to five or more of the clinical quality measures (CQMs) that the provider is expected to report on, be reduced to requiring that interventions be related to two more CQMs in order to reduce burden due to financial and administrative cost associated with clinical decision support systems. Also, because of the difficulty many specialists have in reporting CQMs and the fact that many do not need to implement as many clinical decision support interventions for their particular patient populations, having to implement five or more decision support interventions linked to five or more CQMs would be unnecessarily difficult. Furthermore, we seek clarification on whether these interventions can also be related to five or more CQMs that are a part of the Physician Quality Reporting System (PQRS) measures should a physician choose to report their CQMs under this option. Additionally, we support CMS' proposal to leave it to the provider's clinical discretion to determine the relevant point in patient care when the intervention will be most effective.

The undersigned organizations have no recommendation for or against the consolidation of the drug-drug and drug-allergy check into this measure, however, are concerned about the potential risk for alert fatigue.

Provide Patients with Clinical Summaries:

We support the proposed objective to provide clinical summaries to patients. However, we do not support the "within 24 hours" timeline for more than 50 percent of office visits. It would be very difficult for EPs to have to comply with a 24-hour turn around time for every single patient during every single visit. CMS needs to take into consideration potential problems that may delay an EP from getting a summary out within 24 hours including technological issues, holidays, and other unforeseen circumstances.

The undersigned organizations also support CMS' proposal to allow an EP to choose to withhold information from the clinical summary if he or she believes that substantial harm may arise. We believe that physicians and patients are in the best position to determine what records are needed and when they are needed.

Incorporate Clinical Lab Test Results:

We continue to believe that although lab results are an important part of the EHR, the requirement poses significant problems for some specialties that order a limited number of lab tests. For example, ophthalmologists order a very small number of lab tests, and we are unaware of laboratories providing electronic interface with eye care-only EHR vendors (rather only for large enterprise vendors) because ophthalmologists do not order enough lab tests for the laboratories to find it cost-beneficial to create custom interfaces for data exchange. Because ophthalmologists rarely order lab tests, this is not a functionality currently built into eye care-only EHRs. This functionality is assuming that all physicians use their EHR in the same fashion regardless of true utility.

We appreciate CMS proposing an exclusion criteria for this measure. However, we would encourage CMS to consider that instead of excluding any EP who orders no lab tests whose results are in a positive/negative numeric format during the EHR reporting period, to replace that with a definite number of lab orders (e.g. under 200) so that functionality is not being created for a small number of patients. For example, there may be situations where EPs may order very few lab tests and are unable to meet the exclusion. We also ask CMS to consider moving this measure from the core to the menu set because of applicability to only some physician specialties.

Furthermore, this objective requires incorporating lab data into the EHR, which relies on the exchange of health information. Unfortunately, this technology is currently lagging. In reality, the various EHR systems do not talk with each other; although they may claim to have the ability. The creation of the exchanges is beyond the control of any of the users; to penalize providers for this when they are trying to achieve meaningful use is unfair. Rather, CMS needs to do a better job of ensuring the infrastructure to communicate between users is developed and implemented.

Patient Reminders:

As we previously commented, this is a criterion that may not be appropriate for all specialists. For example, it would make sense for a primary care physician to send reminders to his or her patients with one or more chronic conditions, but may not for a surgeon who treated a patient for some 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. In addition, because those physicians who do communicate with patients use many forms of communication in issuing patient reminders, the reminders should be more flexible e.g. provide multiple methods such as

telephone calls, voice mail messages, emails, or printed reminder notices provided after the initial visit.

Provide Patients with the ability to View and Download Information:

CMS proposes two measures for this objective. The first requirement for core measure 10 is more than 50 percent of all unique patients seen by the EP during the EHR reporting period to be provided with timely (within *four business days* after the information is available to the EP) online access to their health information subject to an EP's discretion to withhold certain information. We strongly believe that this measure will be difficult for providers to achieve because it does not does not take into account the varying patient populations in different physician specialties in which such a requirement may not be feasible, especially for those with a large elderly patient base or those who do not or cannot use the internet adequately. For example, this measure would be problematic if a patient has a condition whereby they are not able to access the computer—and a caregiver or family member is not able to access it either, therefore making the four business day requirement highly difficult to meet. The second measure requires that more than 10 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representative) view, download, or transmit to a third party their health information. CMS recommends that an EP can host a patient portal, contract with a vendor to host a patient portal, connect with an online personal health record, or use any other means up to the EPs' discretion that would allow a patient to view, download, and transmit the information using a standard web browsing and internet connection. Although the undersigned organizations are supportive of patient portals and the ability for patients to be able to review and update their medical information, depending on the EHR vendor product, the incorporation of patient portal capabilities into an EHR is yet an additional cost for providers. Additionally, it may also require practices to spend time educating patients on what they are viewing so they can understand the information without causing confusion. In addition, requiring a measurement of patient use is entirely outside of the control of the EP. For these reasons, the undersigned organizations request CMS to entirely eliminate the second measure for the objective.

We also appreciate CMS reconsidering the Health Information Technology Policy Committee's recommendation for EPs to make the information known to patients within four business days as this arbitrary time limit of four business days is significantly under the 30 days allowed under the Health Insurance Portability and Accountability Act (HIPAA) for providing an electronic copy of health information. In the interest of consistency and mitigating compliance burdens, we ask CMS to consider aligning this objective with the HIPAA requirement.

Medication Reconciliation:

CMS proposes EPs to perform medication reconciliation for more than 65 percent of transitions of care in which the patient is transitioned into the care of the EP. The denominator of this objective is the number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. We seek further clarification of the definition of the word "transitions" in order to better understand the denominator of the population. For example,

we assume that a surgical consultation would not, by itself, be considered a transition of care. However, if surgery were required, would the surgeon incur an obligation to perform medication reconciliation under the proposed measure or would the physician who originally admitted the patient be required to do so?

Record Immunization Data:

CMS proposes a number of exclusions for this measure which include: (1) the EP does not administer any of the immunizations to any of the populations for which data is collected by the jurisdiction's immunization registry or immunization information system during the EHR reporting period, (2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of receiving electronic immunization data in the specific standards for CEHRT at the start of their EHR reporting period; or (3) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the version of the standard that the EP's CEHRT can send at the start of their EHR reporting period. While we support CMS' proposal to add these exclusions to the measure, we also urge CMS to clearly define what they mean by "certified registry," and we also ask CMS to move this measure back into the menu set because of its limited applicability to many physicians.

Report Case Information to Cancer Registries:

We support CMS' proposal to include registry reporting of case information to cancer registries. We agree that successful registry submission of cancer data will help tackle the issue of underreporting. We also support the decision to propose this objective as a menu item since it allows flexibility for participating providers.

The undersigned organizations encourage CMS to consider expanding this registry reporting option to include eligible hospitals. In addition, collection of data on cancer cases from a wider range of care settings will help fill critical gaps in data used for research and quality improvement purposes. Though CMS correctly states that registry reporting infrastructure is less mature outside the hospital setting necessitating the focus on EPs, hospital-based registries remain the mainstay of important data for many cancers types. They therefore are relevant in advancing public health data collection, analysis and reporting.

We support the objective focused on reporting specific case information for diseases associated with other specialized registries similar to those sponsored by professional societies such as the American College of Cardiology, the American College of Surgeons, and The Society of Thoracic Surgeons. Similar to cancer registries, we support extension of this option to eligible hospitals for the same reasons stated above. To ensure successful achievement of this objective, we encourage CMS to provide a more specific definition of a specialized registry. We believe a specialized registry should at a minimum be compliant with prevailing healthcare information privacy laws, be evidence-based, contain a standardized and consensus-based vocabulary, and have a rigorous process for quality assurance.

To further support this objective, we suggest that CMS work with the ONC to promote the standardization of data transfer between EHRs and registries. Given that EHRs use different clinical and technical definitions, data transfer to registries remains a challenge in the absence of data mapping capabilities. While some organizations have implemented home-grown solutions, there is a need to standardize this process at the national level. This will support comparability of data across care settings and contribute to the development of a national healthcare data infrastructure.

Menu Set Objectives

Imaging Results:

The undersigned organizations strongly support CMS' decision to include an objective to address access to patient images in Stage 2 of meaningful use. Images are a routine component of many specialists' workflow, and it is critical that electronic health records have the capability to interface with other systems. This objective also provides image-oriented specialties with a reporting option that is meaningful to their practice. As the meaningful use program incorporates more specialty-relevant objectives, we anticipate that specialists will begin attesting to meaningful use in higher numbers.

Specialized Registries:

The undersigned organizations strongly support the inclusion of this new objective for reporting to specialized registries. We appreciate CMS' effort to include a registry measure that meets the needs of specialists who do not immunize or monitor conditions of interest to syndromic surveillance. Linkages between EHRs and clinical registries facilitate the availability of data for quality improvement at multiple levels. Physicians can use registries for internal performance improvement as well as to monitor progress on specialty-specific population health goals. Registries also allow for the collection of data that is not present in the EHR, such as patient satisfaction and patient-reported outcomes, which add value to clinical outcome measures. Support for reporting to clinical registries through the meaningful use program will further broader quality improvement goals and allow for more continuous feedback to physician practices.

Reporting Clinical Quality Measures Using Certified EHR Technology by Eligible Professionals

Certification Requirements for Clinical Quality Measures:

We value CMS' commitment to aligning quality measures and reporting among the various CMS quality reporting programs. 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. The undersigned organizations are also supportive of CMS' proposal to include measures from the National

Quality Strategy that support both CMS and the Department of Health and Human Services' priorities for improved 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. We ask CMS to continue to identify other areas in which this type of alignment can continue.

The undersigned organizations specifically request that when CMS makes its determination on the subset of CQMs to finalize, that the agency include the two proposed perioperative measures (National Quality Forum measures 0239 and 0271) as this will provide greater opportunities for surgeons to participate in the program. Also, we understand CMS' preference for selecting National Quality Forum endorsed measures, but also highly appreciate CMS' flexibility with selecting measures that are endorsed by other multi-stakeholder groups. 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 ask that CMS consider allowing this expanded list of CQMs be used for Stage 1 in 2013 rather than having to wait until 2014. This will help those EPs who are attempting to comply with Stage 1 requirements, but are having difficulty due to the limited speciality-specific CQM options, to be able to comply with the program.

Proposed Clinical Quality Measures for Eligible Professionals Beginning with CY 2014:

CMS is proposing three options for reporting that would begin in 2014 for both Medicare and Medicaid EPs. For option one, they are contemplating two alternatives. In option 1a, EPs would need to report 12 CQMs from those listed in Table 8 of the proposed rule, including at least 1 measure from each of the 6 proposed domains. If an EP's CEHRT does not contain patient data for at least 12 CQMs, then the EP must report CQMs for which there is patient data and report the remaining required CQMs as "zero denominators." Option 1b requires EPs to report 11 "core" CQMs listed in Table 6 of the proposed rule plus 1 "menu" CQM from Table 8 of the proposed rule. Option 1b might mean that more measures are reported with zero denominators if they are not applicable to certain practices or populations.

The undersigned organizations strongly urge CMS to further expand the list of CQMs to include more measures in PQRS, and for physicians not to have to report on core measures or measures within a specific domain. Many of the measures that are currently proposed are weighted toward primary care and preventive medicine and are difficult for specialists to meet. Instead of choosing to create a more appropriately flexible option, if CMS decides to choose only between the two alternatives for option 1articulated in the proposed rule, the undersigned organizations recommend that CMS select Option 1a. We believe this option provides greater flexibility in reporting in comparison to the second alternative. As long as the "zero denominators" are acceptable, we believe that many physicians would prefer Option 1a. With Option 1b, we fear that it is rather limiting because of the fact that if an EP is unable to report all of the identified core CQMs in addition to a menu set CQM, he or she will not meet the requirement for reporting their CQMs.

In addition to either 1a or 1b above, CMS is also proposing an additional second option which would help streamline quality reporting options for EPs. In this case, EPs who satisfactorily report Physician Quality Reporting System quality measures under the PQRS EHR reporting option using CEHRT would satisfy their CQM reporting requirement under the Medicare EHR Incentive Program. EPs choosing this option would have to comply with the requirements of both programs. We support this option and believe that this will be a beneficial reporting mechanism for physicians as it will help to align both quality reporting programs.

Hospital-Based Eligible Professionals

We appreciate CMS creating flexibility for those providers who may work in specialized units and have obtained and utilize EHR technology distinct from the hospital as they are able to meet meaningful use requirements without using the facilities and equipment of the hospital.

Payment Adjustment Effective in CY 2015 and Subsequent Years for EPs who are not Meaningful users of Certified EHR Technology

CMS proposes that for the purpose of the payment adjustment, that the EPs who are eligible for a Medicaid EHR Incentive payment in a given year and who have adopted, implemented, or upgraded CEHRT, would not be considered meaningful users of EHR and could still be subject to a penalty under the Medicare side of the program. The undersigned organizations urge CMS to reconsider this as it would, in effect, mean that, all EPs are required to demonstrate meaningful use in the first year of program regardless of whether they are participating in Medicare or Medicaid. 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[3]." The language clearly intended to provide flexibility to EPs in the Medicaid EHR Incentive program in their first year of participation. By applying the penalty in their first year of participation in the Medicaid EHR Incentive Program would mean that an EP could be eligible for Medicaid EHR incentive payments and simultaneously incur Medicare EHR payment adjustments. We do not believe that this is an outcome that the Congress intended.

Additionally, CMS proposes that those eligible professionals who receive an incentive for the payment year 2013 to be exempt from the payment adjustment 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 payment adjustment would continue to be the calendar year two years prior to the payment adjustment year. We would urge CMS to tie the payment adjustment year closer to the reporting period for the payment adjustment so that there is less lag time between the two. While we advocate 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

[3] American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, SEC. 4201 (6)(C)(I)(II).123 Stat. 493.

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 thus undermining the opportunities for improvement.

Furthermore, CMS proposes three exceptions to the application of the payment adjustment with the possibility of incorporating a fourth.

The first is for EPs who practice in areas without sufficient internet access as determined two years prior to the payment adjustment year. We support the inclusion of this exception.

The second is an exception for new EPs for two years after they begin practicing. We support this exception.

The third is for extreme circumstances during either of the two years preceding the payment adjustment year which include practices or hospitals being closed down, an EHR vendor going out of business, a natural disaster, etc. We request that CMS re-word this measure to say "external circumstances" instead of "extreme circumstances." We agree that these are foreseeable scenarios under which an exception should be granted. However, if we believe that many of these scenarios, such as an EHR vendor going out of business, is not extreme, but rather a foreseeable and real possibility. There are also instances in which the circumstances deserving of an exception are outside of the EPs control so we believe that the use of the word “external” would better describe the nature of this exception and reduce confusion in its application. The undersigned organizations also urge CMS to consider the fact that some situations may make it impossible for an EP to able to participate in the program for a few years, and should such a situation arise, CMS should clarify whether the EP will be eligible to apply for this exception for more than one year if it is applicable based on the circumstances and whether CMS would be willing to grant this exception for a period of longer than one year as appropriate under the circumstances.

The possible fourth exception that CMS is considering is a combination of three barriers that would constitute a significant hardship. These barriers include: lack of direct interaction with patients, lack of need for follow-up care for patients, and lack of control over the availability of CEHRT. The undersigned organizations would support an exception for each one of the three barriers since even each individual barrier would pose a substantial obstacle to achieving meaningful use. If CMS is worried about the feasibility of allowing this broad of an exception, they can also consider implementing them as three separate exceptions.

We also recommend four additional exceptions:

First, we request CMS to make an exception from the EHR CQM requirements for those EPs who are reporting via PQRS and have measures that are not ready to be reported via the PQRS EHR Reporting option through no fault of their own. Many specialties have worked tremendously hard to get measures into PQRS, but many of these measures are not yet ready for EHR reporting because CMS has not created electronic specifications for them. Because many specialties have difficulty reporting the CQMs, but have measures available in PQRS, we believe that this exception will help those specialties as a bridge to the date when the electronic specifications exist to allow for PQRS EHR Reporting. We believe that this is an exception that EPs should reapply for on a yearly basis.

The second exception that we propose is for those EPs who are participating in their first year of the Medicaid EHR Incentive Program. We believe that those EPs who receive the Medicaid incentive payment by adopting, implementing, or upgrading a certified EHR should be exempt from the Medicare penalty. States are moving at different paces attempting to implement the Medicaid versions of the program, and penalizing providers who are in their first year of the Medicaid program and thus not required to achieve meaningful use (flexibility in Medicaid that was created by Congress) would be unfair non-sensical, especially in those cases where an individual's State was late to launch the State's Medicaid Incentive Program. This exception would only need to last for one calendar year because by the following year the EP would be required to demonstrate meaningful use under the Medicaid program as well.

Third, we ask CMS to consider creating an exception for those EPs who are either currently eligible or will be eligible for social security and retirement benefits by 2014. There are many physicians who are who are either currently eligible, or close to being eligible, for whom the cost of investing in an EHR system would be economically burdensome and unfeasible. As a result, some providers may decide to opt out of Medicare in order to avoid penalties. We do not believe that CMS or this program should create an incentive for many of our physicians who have devoted their lives to medicine to retire earlier than they otherwise would have, especially with the increasing health needs of our society. We believe that this exception should be one year long with eligibility to apply again in each subsequent year.

Finally we would also recommend CMS to implement an additional 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, could 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 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. For those EPs who were not part of the

Medicare program or eligible for an exception for being in the first two years of practice, Medicare should make their hospital-based determination after they have had a full year in the program.

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 you seriously consider the concerns of anesthesiologists. Currently, anesthesiologists, despite Congressional intent, are not considered hospital-based eligible professionals by CMS, yet they face regulatory barriers when attempting to become meaningful users of EHRs. The American Society of Anesthesiologists has submitted a separate comment letter that outlines those concerns in further detail.

Proposed Administrative Review Process of Certain EHR Incentive Program Determinations

CMS is proposing to provide a limited appeals process for providers challenging whether they met the regulatory standards and methods set forth by CMS in its rules. CMS proposes three types of appeals: (1) eligibility appeals, (2) meaningful use appeals, or (3) incentive payment appeals. The undersigned organizations are supportive and appreciative of the appeals process for this program, but urges CMS to define the word "limited" as the language appears rather inappropriate.

Collection of Information Requirements

CMS estimates that it would take an EP about eight hours and twelve minutes to complete their attestation for the core set of objectives and anywhere from three to twenty-one minutes to complete their attestation for the three menu set objectives and other associated measures. The agency also estimates that it would take about two hours to select, prepare, and electronically submit twelve CQMs. We believe that this is an underestimation of the how much time many EPs will actually spend.

The underscored organizations appreciate the opportunity to offer these comments and look forward to continuing to work with CMS in order to provide additional feedback regarding Meaningful Use. If you have any questions about our comments, please contact Bob Jasak at 202-672-1508 or bjasak@facs.org.

Sincerely,

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

The American Congress of Obstetricians and Gynecologists

American Osteopathic Academy of Orthopedics

American Pediatric Surgical Association

American Society for Surgery of the Hand

American Society of Anesthesiologists

American Society of Cataract and Refractive Surgery

American Society of Colon and Rectal Surgeons

American Society of General Surgeons

American Society of Metabolic and Bariatric Surgery

American Society of Plastic Surgeons

American Urological Association

Congress of Neurological Surgeons

Society for Vascular Surgery

The Society of Thoracic Surgeons