



**American
Academy of
Home Care
Medicine**



June 15, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3311-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-3311-P, Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 to 2017 (Vol. 80, No. 72), April 15, 2015

Dear Administrator Slavitt:

We are writing on behalf of the American Academy of Home Care Medicine (Academy) to submit comments regarding the regulation proposed by the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 to 2017.

The Academy represents physicians, nurse practitioners, and physician assistants who provide house calls to some of Medicare's sickest and most costly beneficiaries—those with multiple chronic conditions who are home-limited due to illness and disability. These beneficiaries, in addition to their home limiting medical condition, are also often physically isolated and located in medically underserved areas.

Summary of Key Issues and Recommendations

The Academy supports;

- The 90-consecutive day reporting for 2015 and urge this reporting time frame be implemented for all years of the program.
- The modifications to the view, download or transmit and secure messaging requirements.
- The reporting requirements set forth in this modification rule, and urge CMS to adopt them for program years 2015-2019.
- The proposed hardship exceptions and encourage CMS to create additional hardship categories.

Comments and Recommendations

The Academy provides the following comments and recommendations for this Stage 2 modification rule. These will support CMS goals for implementation of EHR technology while also providing for EP success in the program.

Continue with revised Stage 2 requirements through 2019

We join with other medical organizations recommending that the Stage 3 final rule be delayed until the Merit-Based Incentive Payment System (MIPS) framework is developed. We also urge CMS to adopt the Stage 2 requirements that are proposed in this rule. This would offer continuity for those EPs currently participating in the program and at the same time provide a reasonable path for new EPs looking to participate.

2015 meaningful use reporting period

CMS proposes the following:

“For 2015 only, we are proposing to allow eligible hospitals and CAHs (regardless of their prior participation in the program) to attest to an EHR reporting period of any continuous 90-day period within the period beginning October 1, 2014 and the close of the 2015 calendar year. This 90-day EHR reporting period for 2015 would allow providers additional time to address any remaining issues with the implementation of technology certified to the 2014 Edition and to accommodate the changes to the objectives and measures of meaningful use proposed in this rule.”

Comment

We support the proposal to limit EP reporting in 2015 to 90 consecutive days. This will permit EPs to work with their software vendors to ensure that their EHR systems are appropriately configured for the modified Stage 2 requirements.

2016 meaningful use reporting period

CMS proposes the following:

“In 2016, we propose EPs, eligible hospitals, and CAHs that are demonstrating meaningful use for the first time may use an EHR reporting period of any continuous 90- day period between January 1, 2016 and December 31, 2016. However, all returning participants would use an EHR reporting period of a full calendar year from January 1, 2016 through December 31, 2016. In 2017, all providers, both new and existing participants, would use an EHR reporting period of 1 full calendar year as proposed in the Stage 3 proposed rule at (80 FR 16737 through 16739) with a limited exception for Medicaid providers demonstrating meaningful use for the first time.”

Comment

We oppose the proposal to expand the length of the reporting period in 2016 and beyond to a full year. EPs should only be required to report for 90 consecutive days during any reporting year of the meaningful use program.

We believe the statute supports the view that there is no obligation for CMS to require a year for reporting. Beyond the lack of statutory support for CMS to require a year there are practical reasons why this will discourage EPs from participation and just practically increases risk of non-success. This is due to marketplace factors where EPs are unable to meet a full-year reporting requirement. These factors could include multiple scenarios where EPs have to make a change in EHR vendor that disrupts operations including meaningful use reporting.

Involuntary change could occur because an EHR vendor decided to discontinue produce support and this happens in consolidation industries such as health information technology, or the vendor decided not to certify their product for Stage 2 of the program. Other issues beyond the EPs control are environmental, infrastructure problems, and EP practice staffing continuity.

Additionally, there is movement of EPs from one practice to another setting and also the merger of practices or absorption of practices within health system or health plans in a fluid and responsive market. This dynamic market is due in great part to the revenue and regulatory pressures of Medicare and other important payors. As a result, extending the reporting period to an entire year, again, in the absence of statutory mandate, will have the unintended consequence of unfairly penalizing those EPs who participate in the program but fail to report for the entire year.

CQM reporting

CMS proposes the following:

“For an EHR reporting period in 2015, and for providers demonstrating meaningful use for the first time in 2016, we are proposing that providers may—

- *Attest to any continuous 90-day period of CQM data during the calendar year through the Medicare EHR Incentive Program registration and attestation site; or*
 - *Electronically report CQM data using the established methods for electronic reporting.*
- For 2016 and subsequent years, providers beyond their first year of meaningful use may attest to one full calendar year of CQM data or they may electronically report their CQM data using the established methods for electronic reporting outlined in section II.C. of this proposed rule.”*

Comment

We support the proposal to permit EPs to attest to any continuous 90-day period of clinical quality measures (CQM) data. However, for the reasons stated above oppose the requirement to expand the CQM reporting period to a full-year starting in 2016. This 90-day reporting period should also be applied to the Physician Quality Reporting Program (PQRS) to ensure seamless alignment between meaningful use and PQRS. EPs should be able to report CQMs one time and have this count toward both programs.

View, Download or Transmit (VDT) and Secure Messaging requirements

CMS proposes the following:

“Patient Action To View, Download, or Transmit Health Information ++ Remove the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access (VDT) objective. Instead require that at least 1 patient seen by the provider during the EHR reporting period views, downloads, or transmits his or her health information to a third party. This would demonstrate the capability is fully enabled and workflows to support the action have been established by the provider... Convert the measure for the Stage 2 EP Secure Electronic Messaging objective from the 5 percent threshold to a yes/no attestation to the statement: ‘The capability for patients to send and receive a secure electronic message was enabled during the EHR reporting period.’”

Comment

We support these proposals and believe that easing the VDT and secure messaging requirements will decrease the administrative burden for EPs seeking to meet these objectives. Additionally, the patient population for our members is less likely to VDT based on lack of a computer and computer competence. Factors of age, cognitive, and financial status all play a role in reducing the likelihood that such patients will make use of VDT or secure messaging. Also the fact that the encounter for Academy members takes place in the patient's home and is of longer duration than office based encounters reduces some of the need that may arise from an office encounter.

We also recommend should CMS require any formal threshold in the future that administrative transactions such as scheduling and medication re-fills be permitted to count toward the numerator, including those that occurred prior to, or in lieu of, a face-to-face visit with the EP. This also confirms with documentation requirements to have information relating to the new Chronic Care Management service documented in the medical record. Finally, we also believe that any online participation in patient satisfaction or quality improvement initiative should count in the numerator. This also dovetails with patient satisfaction reporting requirements in growing CMS shared savings programs and also those value based payment programs of private plans.

Summary of care

CMS proposes the following:

“Summary of Care- We are proposing to retain only the second measure of the existing Stage 2 objective for Summary of Care for meaningful use in 2015 through 2017 with the modifications discussed in this proposed rule. (For further information and discussion of the existing Stage 2 Summary of Care objective and measures, we refer readers to the discussion in the Stage 2 final rule at 77 FR 54013 through 54021.) Proposed Objective: The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral. In the Stage 2 final rule, we outlined the following benefits of this objective. By assuring lines of communication between providers caring for the same patient, all of the providers of care can operate with better information and more effectively coordinate the care they provide. Electronic health records, especially when linked directly or through health information exchanges, reduce the burden of such communication. The purpose of this objective is to ensure a summary of care record is provided to the receiving provider when a patient is transitioning to a new provider or has been referred to another provider while remaining in the care of the referring provider.

Proposed Measure: The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care that—(1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.”

Comment:

While we appreciate the proposed rule's reduced requirements, we also recommend CMS develop clear guidance to assist EPs in understanding transmission options. Beyond any impact that alternative electronic delivery pathways could have to reduce administrative costs, this supports the potential for better tracking and management of patients that in turn could

support improved care and reduced cost. The Academy has learned that its members participating in CMS and other shared savings programs are making efforts to electronically transfer the summary of care outside of EMR to EMR interface. While such efforts are expected to grow we also encourage CMS to survey EP summary of care transmission costs and burdens and modify this measure should the evidence suggest EPs are being subjected to overly expensive or burdensome processes.

Quality measure program enhancements

We support CMS intent to better align meaningful use clinical quality requirements with PQRS. However, for reasons discussed above we recommend allowing the 2015 meaningful use 90-day reporting period (versus full year), to count toward successfully meeting the quality reporting requirements for PQRS, as well as the Value-Based Payment Modifier.

Security objective

CMS proposes the following:

“Proposed Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process.”

Comment

Given that conduct of risk analyses including encryption is already required under HIPAA, we encourage CMS to work with the DHHS Office for Civil Rights (OCR) to develop guidance and educational materials to assist physician practices in understanding specific requirements for risk analysis, mitigation and for implementing encryption. We also note the increasingly challenged environment for EHRs given the national increase in cyber attacks. Guidance and education would be especially important for small practices such as those in the Academy that have limited internal technical resources that are not devoted to direct clinical care.

Alignment of program reporting periods

CMS proposes the following:

“We are proposing to align the definition of an EHR reporting period with the calendar year for all providers beginning in 2015 and continuing through 2016 onward. Specifically, this proposal would change the EHR reporting period for eligible hospitals and CAHs from a period based on the fiscal year to the calendar year beginning in 2015. This aligns with the provision outlined in the Stage 3 proposed rule to move all providers to an EHR reporting period of 1 full calendar year beginning in 2017 with a limited exception for Medicaid providers demonstrating meaningful use for the first time (80 FR 16734 and 80 FR 16737 through 16739).”

Comment

We support the alignment of the EP and hospital reporting periods. Some Academy members practice across inpatient and outpatient settings. This may grow with an understanding of the importance of tracking and management of patients across settings. Also as noted above there is continuing acquisition and relationship of practices with health systems. Alignment of reporting will help to support the recognition of reporting programs across management and providers alike regardless of their practice setting.

Definition of a “hospital-based EP”

CMS proposes the following:

“However, recently several hospital associations, individual providers, and other stakeholders have raised concerns with our current definition of a hospital based EP. Specifically, these stakeholders asserted that the limitation of hospital-based to POS codes 21 and 23, covering inpatient and emergency room settings only, does not adequately capture all settings where services might be furnished by a hospital-based EP. They stated that POS 22, which covers an outpatient hospital place of service, is also billed by hospital-based EPs, especially in relation to certain CPT codes. These stakeholders expressed the belief that our current definition of hospital-based EP in the regulations is too narrow and will unfairly subject many EPs who are not hospital-based under our definition, but who stakeholders would consider to be hospital-based, to the downward payment adjustment under Medicare in 2015. Accordingly, these stakeholders recommended that we consider adding additional place of service codes or settings to the regulatory definition of hospital-based EP. We appreciate this feedback from stakeholders and are requesting public comment on our current definition of a hospital-based EP under § 495.4 for the EHR Incentive Programs.”

Comment

We support the consideration by CMS to expand the definition of “hospital-based” EP. Academy members as mentioned practice across settings and their organizational base may be the hospital outpatient setting. As a result, this may impact their ability to meet meaningful use requirements on system focused CEHRT.

Hardship exceptions

The rule states the following:

“In this proposed rule, we propose no changes to the existing hardship exceptions under our regulations.”

Comment:

We support the existing hardship exceptions:

1. *The lack of availability of internet access or barriers to obtain IT infrastructure.*
2. *A time-limited exception for newly practicing EPs or new hospitals that would not otherwise be able to avoid payment adjustments.*
3. *Unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis.*

4. *Exceptions due to a combination of clinical features limiting a provider's interaction with patients or, if the EP practices at multiple locations, lack of control over the availability of CEHRT at practice locations constituting 50% or more of encounters.*

We recommend consideration of exceptions for the following circumstances:

1. CMS should extend the hardship time frame for new EPs to five years as these EPs are gaining valuable experience during this time, often in practice settings over which they exert little control and, yet, these EPs are important additions to the primary care workforce.
2. Correspondingly, CMS should extend a blanket exception to older EPs at a certain age or eligible for Social Security benefits. Given the constrained Medicare Fee Schedule, combined with the ongoing operation of the 2% sequestration cuts, Medicare payments have been frozen. The SGR repeal through MACRA will only add .5% a year against a backdrop of future adjustments under MIPS. This is in the context of 10,000 beneficiaries being added to the Medicare program a day. Medicare needs to do all it can to retain the services of primary care EPs who continue to practice though will not be doing so over enough years to recoup the financial and organizational cost of adopting EHR. An exception is requested for these EPs whose services are important to retain and who should not be penalized for where they are in their career phase relative to the meaningful use program.
3. CMS should provide an exception for EPs who are involved in practice transition or transaction that places them in a situation where CEHRT product will be changed as a result of the transaction, or where the practice entity is not in existence for the full year.

We appreciate the opportunity to comment and hope the above comments are helpful. If you have questions about these comments or need more information, please contact Gary Swartz, Associate Executive Director at Gary.Swartz@aahcm.org or 410-962-0565.

Sincerely,

Gary Swartz

Gary Swartz, JD, MPA
Associate Executive Director