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Via Electronic Submission (www.regulations.gov)

June 15, 2015

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

Dear Acting Administrator Slavitt:

Re: Medicare and Medicaid Programs: Electronic Health Record (EHR) Incentive Program-Modifications to Meaningful Use in 2015 through 2017 Proposed Rule, File Code CMS-3311-P

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) Proposed Rule entitled *Medicare and Medicaid Programs: Electronic Health Record Incentive Program- Modifications to Meaningful Use in 2015 through 2017.* 80 *Fed. Reg*. 20346-20399 (April 15, 2015). The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC commends CMS for the Agency's efforts to streamline and simplify many of the meaningful use requirements across hospitals and eligible professionals (EPs). In this modification rule, CMS removes several topped-out measures and appropriately modifies some Stage 2 measures to recognize the implementation issues many providers are experiencing. The AAMC is concerned, however, that CMS underestimates the planning required to address certain changes within the proposed timeframe.

KEY RECOMMENDATIONS

- Do not implement mandatory calendar year (CY) reporting for hospitals until CY 2017;
- Implement a shortened reporting period for 2015, with a slight modification to allow providers to choose a calendar quarter reporting period versus a 90-day reporting period;
- Extend the consolidated attestation period from 60 days to 90-120 days; open the hospital fiscal year (FY) 2015 attestation period by October 1, 2015;

- Finalize the proposed changes to meaningful use objectives that provide greater flexibility for hospitals and EPs, including changes to the patient electronic access measures and removing redundant measures; and
- Refrain from making any changes to the meaningful use objectives and measures that make achieving meaningful use Stage 2 more difficult, such as accelerating the date by which a new provider must meet Stage 2, making e-prescribing of discharge medications mandatory, or adding new public health reporting measures.

ISSUES WITH THE STRUCTURE OF THE MEANINGFUL USE PROGRAM

Aligning Hospital Reporting Period with Calendar Year

In the 2015-2017 Modifications rule, CMS proposes to change the definitions of "EHR reporting period" and "EHR reporting period for a payment adjustment year" such that, beginning in CY 2015, the EHR reporting period would be a full CY. Under the current definition, eligible hospitals report on a federal FY basis.

Although the AAMC supports the principle of aligning the hospital reporting period with the CY reporting period currently in use for EPs, CMS should *not* implement mandatory CY reporting for eligible hospitals *prior to* CY 2017. Instead, for FYs 2015 and 2016, CMS should grant hospitals the option of choosing whether to report on a federal FY or CY basis. Hospitals have already made reporting plans and fiscal projections for these years. CMS should consider these years as an appropriate period of transition to calendar-year reporting.

Additionally, the AAMC urges CMS to clarify in the final rule whether and how a shift to CY reporting would affect an eligible hospital's payment or penalty period. Final EHR payments for eligible hospitals are based on the 12-month cost reporting period for the hospital FY that starts after the beginning of the payment year. Therefore, during the transition in reporting period from FY to CY, hospitals with FYs beginning October 1 would benefit from an explanation as to which cost reporting period will be affected by which reporting period.

Adopting a 90-Day EHR Reporting Period for All Providers in 2015

The AAMC strongly supports CMS' proposal to shorten the 2015 reporting period for all providers to 90 days, rather than a full year. Given the need for providers to implement changes proposed in this rule, the Association agrees that a shorter reporting period is entirely appropriate.

The AAMC also recommends a minor change to the newly-proposed definition of "EHR reporting period" such that providers have the option to choose *either* a 90-day consecutive reporting period *or* a calendar quarter. Some AAMC-member hospitals have struggled with administrative burdens of having a reporting period equal to an exact 90-day period and would

benefit from being able to report for a 91 or 92-day period that coincides with their calendar quarter.

60-Day Attestation Period for All Providers from January 1 – February 29, 2016

In the 2015-2017 Modifications proposed rule, CMS proposes to delay the attestation period for all hospitals to the period from January 1 through February 29, 2016, to account for the shift to calendar year reporting and to permit CMS more time "to make the system changes necessary to accept attestations reflecting the proposals in this proposed rule." The results of this shift will lead to (1) a requirement that all providers (EPs and hospitals) attest during the exact same timeframe, and (2) a delay in incentive payments to hospitals by a full calendar quarter.

The AAMC strongly disagrees with CMS's proposed attestation timeframe as being both too short a window and too late a period for hospitals to attest. CMS has a history of technical problems with the attestation process, and the Association has significant concerns about the Agency's ability to process the *all* EP and hospital attestations within a single 60-day timeframe. The AAMC instead recommends that CMS open the attestation window for a period between 90 and 120 days.

The Association also urges CMS to enable the Agency's attestation system for hospitals by October 1, 2015, so that hospitals that have completed a 90-day reporting period by that date can receive their incentive payments as originally planned. CMS acknowledges that moving the attestation window to early 2016 would result in a delay of hospital incentive payments but believes the "negative impact of this change would be minimal and outweighed by the opportunity to capitalize on efficiencies created by aligning the EHR reporting periods across EPs, eligible hospitals, and CAHs." The AAMC respectfully disagrees that the negative impact of this change would be "minimal." Hospitals are relying on expectations that they will receive significant incentive payments reasonably anticipated to arrive during a certain calendar quarter. Changing the attestation period has broad implications for overall hospital financial planning, and for certain hospitals may even delay payments to a later hospital fiscal year. Given that it is only June 2015, the AAMC believes CMS has sufficient time to update attestation systems and enable them for hospitals beginning October 1, 2015.

Medicaid Attestation Sufficient for Hospitals Eligible for Meaningful Use under Both Medicare and Medicaid

CMS proposes that beginning in 2017, hospitals that are eligible for meaningful use under both the Medicare and Medicaid programs will no longer be required to go through the attestation process for both programs. Rather, to avoid duplicative reporting, Medicaid attestation by these hospitals will be sufficient for both Medicare and Medicaid. The AAMC agrees with the Agency's proposal and appreciates CMS' willingness to reduce administrative burden for attesting hospitals.

Permitting Stage 3 as an Option in 2017

CMS proposes that Stage 3 be optional for providers in 2017 and requests comment on whether to permit providers who are prepared to transition to Stage 3 by 2017 the option of doing so. As discussed in the Association's comment letter on Meaningful Use Stage 3, the AAMC urges CMS to delay Stage 3 implementation in its entirety. If, however, the Agency decides to move forward in finalizing a Stage 3 rule this year, AAMC supports the proposal to make Stage 3 an option in 2017 for providers who are prepared to advance to that stage. Having a cohort of early adopters advance to Stage 3 in 2017 could help identify issues or barriers before Stage 3 becomes required for all other providers the following year.

Alternative Method of Demonstration for Certain Medicaid Providers

The AAMC agrees with CMS that EPs should not be penalized under the EHR Incentive Program if the providers are using an EHR yet are unable to attest for Medicaid because of program rules. CMS identifies an important case: Medicaid physicians who previously received a Medicaid EHR Incentive payment but no longer meet the Medicaid thresholds in the performance year. Because these individuals cannot attest to the *Medicaid* program, they technically have not met meaningful use and may be subject to the *Medicare* EHR Incentive Program penalties. The AAMC supports CMS' proposal to create an alternate Medicare attestation process for these individuals so that the EPs can avoid the penalty.

Hospital-Based Eligible Professionals

As the EHR Incentive Program transitions from incentives to penalties, CMS is seeking feedback on whether the definition of hospital-based EPs should be modified. The AAMC believes it is reasonable to have separate standards for incentives versus penalties. The Association cautions against expanding the definition of hospital-based for purposes of incentive payments, as the incentives are phasing out and the EPs who invested in such technology should be able to receive their payments. As for the place of service, the AAMC believes that, at a minimum, all inpatient places of services including inpatient psychiatric facilities (place of service 51) should be considered hospital-based.

<u>OVERARCHING ISSUES RELATED TO OBJECTIVES AND MEASURES</u>

While the AAMC has concerns about the feasibility and structure of some specific measures, the Association generally supports CMS' efforts to simplify and align the reporting objectives and requirements for hospitals and EPs and to remove redundant measures. The following outlines AAMC comments on the overarching proposals related to the objectives and measures.

Eliminating "Topped-Out" Measures

The AAMC supports CMS' approach to eliminating "topped-out" measures. CMS proposes to eliminate from the meaningful use program certain "topped out" measures for which performance among providers is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. Under the Agency's proposal, CMS will evaluate whether a measure is topped out using the following criteria: (1) statistically indistinguishable performance at the 75th and 99th percentile, and (2) performance distribution curves at the 25th, 50th, and 75th percentiles as compared to the required measure threshold.

Removal of Stage 1 after 2015

The AAMC does not support the removal of a Stage 1 option after 2015. Organizations plan EHR implementation over several years. Six months remaining in 2015 does not provide sufficient time to ensure that all Stage 1 EPs and hospitals will be able to transition and meet the modified Stage 2 thresholds and measures starting January 1, 2016. The AAMC recommends that CMS keep a Stage 1 reporting option for EPs and hospitals that would previously have been eligible to attest to Stage 1.

ISSUES RELATED TO SELECTED OBJECTIVES AND MEASURES

E-Prescribing

The AAMC does not support the requirement to make e-prescribing mandatory for hospitals starting in 2016. Hospitals need time to ensure medication orders are correctly managed in the workflow. The AAMC recommends leaving this requirement as optional at least through the end of 2016 to provide hospitals enough time to implement what was previously a menu measure.

Patient Electronic Access to Health Information

The patient electronic access objective has two measures: (1) provide access to view, download and transmit information, and (2) for patients to view, download or transmit their health information. The purpose of these requirements is to improve current patient engagement through the use of the EHR. CMS acknowledges that median provider performance on these measures is around 20 percent, though there is wide variation. Under the proposed modifications rule, the first measure for both hospitals and EPs is unchanged from the Stage 2 measure: more than 50 percent of all patients have timely online access to their health information. The second measure for EPs and hospitals requires that at least one patient view, download, or transmit his/her health information to a third party. The proposed modifications are intended to mitigate problems and allow providers time to work with patients to educate them about these resources.

The AAMC appreciates CMS' recognition that while EPs and hospitals support the goal of engaging with patients through the EHR, they have been struggling to meet measures related to

actions taken by patients. The Association strongly supports the 2015-2017 modifications. The AAMC continues to oppose measures that rely on the actions of patients, as neither EPs nor hospitals have the ability to control those actions which rely on many factors, especially preferences regarding the preferred form of communication. CMS should be reticent to go beyond the modifications thresholds until such time as electronic communication is widely embraced by patients.

Public Health and Clinical Data Registry Reporting

In the modifications proposed rule, CMS proposes to consolidate the Stage 2 core and menu objectives into one objective with multiple measure options. EPs and hospitals would need to demonstrate active engagement with a Public Health Agency (PHA) or clinical data registry (CDR) demonstrating movement toward sending production data to a PHA or CDR. EPs would be required to successfully attest to 2 of 5 measures; hospitals would be required to attest to 3 of 6 measures.

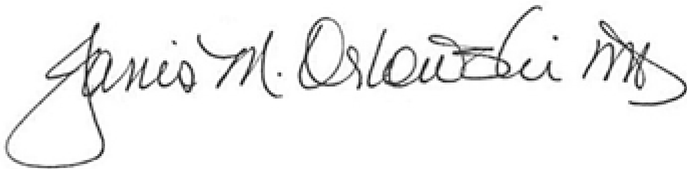
The AAMC is concerned that because the requirements apply only to EPs and hospitals, there is no incentive for state and local PHAs to comply with the standards in time to meet meaningful use measures. There also can be substantial cost related to registry reporting, which may prove very burdensome for faculty practice plans. It is also unclear how this type of public reporting will align with other programs such as the Physician Quality Reporting System (PQRS).

The AAMC recognizes the importance of the concept of “active engagement” with a public health agency or clinical data registry but is concerned about the lack of readiness of many public health agencies to receive data electronically. At this time, CMS should work on supporting public health departments as they improve their capability to receive information electronically. It also would be helpful if CMS and other federal agencies created a single website for providers that lists all public health departments and registries that are able to accept electronic reports that comply with the standards established by the Office of the National Coordinator for Health Information Technology. It may be appropriate to add new reporting requirements for EPs and hospitals at a later time.

CONCLUSION

Thank you for the opportunity to present our views. If you have any questions concerning these comments, please feel free to contact Ivy Baer, at ibaer@aamc.org or at 202-828-0499.

Sincerely,



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