



July 21, 2014

Ms. Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014; and Health Information Technology: Revisions to the Certified EHR Technology Definition

Dear Administrator Tavenner:

I am writing today on behalf of the members of the American Medical Group Association (AMGA). We appreciate the opportunity to provide input on this proposed rule, and other concerns with the Medicare and Medicaid Electronic Health Record Incentive Program that we have heard from member medical groups. AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA represents 435 medical groups throughout the country that employ nearly 130,000 physicians who treat approximately one in three patients in the United States. Most AMGA member medical groups have been early adopters of health information technology to help them deliver high-quality, coordinated care to their patients in a team-based and collaborative manner. As such, they have been eager to embrace the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program.

While we appreciate the new flexibility afforded by the proposed rule, we have been engaged in recent discussions with representatives of several of our member medical groups about their concerns with Stage 2 of Meaningful Use (MU), and this proposed rule. They have uniformly expressed the need for substantive changes to the Medicare and Medicaid EHR Incentive programs in order to make Stage 2 successful, and to accomplish its goals, which we support. Our specific concerns, and recommendations to address them, follow in the paragraphs below.

Vendor Readiness

Our member medical groups have expressed widespread concern about the lack of vendor readiness for Stage 2, which the proposed rule addresses. The certified EHR vendors have worked under extreme deadlines that have forced them to rush their products to market, sometimes at the very last moment, which, in many cases, does not provide enough time for medical groups to upgrade their systems to ensure smooth functioning. In some cases, medical groups will not receive their Stage 2 system

upgrades from vendors until June of this year. This timeframe leaves little time for testing the ability to report, or to address inevitable system problems in implementation.

Several medical groups are concerned about whether the reporting in their EHR is functioning correctly, and they are concerned that mistakes in reporting that are not identified, given the tight timeframe, could jeopardize their ability to attest to MU in 2014. In addition, for physicians who are attesting for the first time during the second quarter of 2014, the only chance for them to get certified is from July 1 to September 30. Then medical groups only have until October 1 to attest to these physicians' MU in order to avoid the payment penalties in 2016. This tight timeframe may not allow enough time for successful attestation, given the potential difficulties with the attestation website, such as those that took place earlier this year. We urge the agency to allow more time for those attesting for the first time.

Our member medical groups suggest that substantive modifications to the program should be announced much sooner, and that EHR vendors should have more time to respond, given long development cycles required by the program, the time needed to thoroughly test them, and the time that is required to provide updates to customers. Currently, EHR vendors are almost exclusively focused on bringing products that comply with the requirements for the EHR Incentive Program to market, rather than working to develop products that will support the redesign the health care delivery system from one that is volume-based to one that is value-based. We therefore appreciate the added flexibility afforded to providers who may instead elect to continue using 2011 CEHRT or a combination of 2011 and 2014 CEHRT for EHR reporting period in 2014, and we urge CMS in its final rule to clarify precisely how providers will need to demonstrate and document their inability to implement 2014 CEHRT, or the need to use a combination of 2011 and 2014 CEHRT. This flexibility should be allowed without qualification.

In addition, for 2015, we urge CMS to allow eligible professionals (EPs) and hospitals to choose a 90-day reporting period, rather than report on a full year. A 90-day, or calendar quarter, reporting period in 2015 would be helpful given the delays in availability, deployment, configuration, implementation and effective use of 2014 CEHRT. In addition, members have expressed concern regarding CMS certification numbers for CEHRT, which are upgraded throughout the year for MU, and other purposes, which can present difficulties with attestation. Hopefully the final rule will provide clarity around these issues.

Transitions of Care

Further concerns center on difficulties in attaining the requirements for transitions of care and the summary of the care record, given a general lack of coordination with outside entities. In addition, outside entities are often competitors in the local health care marketplace, further complicating the issue, and inappropriately placing control for meeting requirements in the hands of others. Health Information Services Providers (HISPs) can play a vital role in helping to resolve these issues, however, they are coming on-line slowly, and there is little information available about whom is HISP connected. Moreover, HISP technology is experiencing growing pains that could ultimately threaten the ability of medical groups to attest properly, if readiness continues to lag.

One approach to resolving these issues going forward would be to place more responsibility on the EHR vendors to create interoperability around a single standard so that systems can exchange information without the intermediation that is currently required, while allowing more time for the interconnection technologies to be proven to work. The regulatory framework should be modified to avoid the situation

of having competitors, or non-participants in the program, contribute to a medical group's success in the program.

In the context of EHR-to-EHR exchanges of information, the lack of a National Direct Address Directory is a major impediment. Absent such a directory, which CMS could assemble and maintain, local versions of addresses are being created, and the result in many cases is that individual providers or facilities will have multiple addresses, which creates considerable confusion.

Patient Portal Engagement

Under the current regulatory framework, providers are required to assist patients with logging on to patient portals so that they may view, download, and transmit their health information, as well as send a secure electronic message to their provider. AMGA member medical groups participating in MU Stage 2 recognize the importance of patient engagement, through the use of patient portals, in achieving better health outcomes. However, significant concerns exist that the current requirement for the portals could be challenging to the point of causing physicians to fail to attest.

The level of enrollment and engagement required from providers to support the use of patient portals does not currently take into account the amount of difficulty involved in convincing patients of their benefit, making it difficult for providers to reach the levels required by the core measure. Due to recent high-profile cases regarding security breaches of electronic information, many patients are reluctant to enroll and utilize portals. The decision to use a patient portal is completely within the discretion of the patient, yet medical groups are held accountable for their choice. In an effort to comply with the patient portal requirement, many providers may be forced to use a portion of their patients' office visits to counsel the patient on utilizing the portal and assisting with the enrollment process, eroding the clinically-oriented time spent over the course of a day, which is not an efficient use of a clinician's, or a staff person's, time.

Furthermore, the requirement that a certain number of patients send electronic messages does not take into account disparate communication styles among health care providers. Health care providers who communicate consistently and effectively with their patients will have less of a need to do so electronically than those providers who communicate less effectively. Patients will only send messages electronically when they feel the need to do so. Requiring that they do only serves to create more work on the part of providers to pressure patients to send electronic messages regardless of whether or not that need exists. Further complicating compliance with this measure is a lack of reporting from some EHR vendors about the number of patients utilizing a patient portal.

All of these issues contribute to an extremely challenging situation that requires extensive clinical and staff time to resolve. The requirements for meeting this measure should be phased-in more slowly over several years, since changing the behavior of patients, medical group staff, and even the culture within medical group practices takes time.

Physicians Who Change Jobs

Physicians who transition to new jobs face unique obstacles to achieving and attesting to MU requirements. When a physician begins at a new practice, the reports from the former practice and the new practice may not be "apples to apples," and they may not have access to the patient data at their former practice to support potential future audits in the program. In addition, outside medical groups

may be reluctant to, or refuse, to share this data once a physician moves on to another employment situation.

In the case of Medicaid incentives, the patient volume from the previous 12-month period is not always available from a previous employer, which hinders the ability of the new employer to attest. Physicians can also be confused about how many CEHRTS they are working within, which versions, and whether they are certified for ambulatory care or for inpatient criteria.

These issues highlight the potential difficulty in accessing the needed information to successfully attest to MU, and the administrative burdens the requirements create.

Group Practice-Specific Issues

AMGA member medical groups, which are among the largest and most progressive medical groups and health care delivery systems in the nation, are actively working to transition the health care delivery system from the current volume-based payment system to a value-based system, but report that their efforts are being hindered by the current regulatory framework. EHR vendors are reacting to the need to develop new products to meet each successive round of MU requirements, instead of tailoring their products toward redesign of the health care delivery system. For example, readmission prevention and value-based contracts are requiring diverse medical groups to work together to provide for seamless transitions in care from one setting to another, and the use of different software to coordinate these efforts across a community. Stage 2 MU requirements do not account for the many creative approaches being employed to achieve this goal, but instead place strict documentation requirements on top of the actual solutions. MU requirements could be directed toward requiring EHR vendors to work on a fully interoperable standard that allows smooth exchange of information across systems without intermediation by HISP's or Health Information Exchanges (HIEs).

The current regulatory framework for MU fails to recognize the synergies between health care providers who work in a group practice setting, and we urge CMS to continue to create appropriate ways for group-level reporting to take place. Creating additional MU exceptions for medical groups that are adopting other value-based reimbursement systems could help address this issue.

Moreover, medical groups and the federal government are expending significant resources on the cost of MU audits. We firmly believe that these resources could be more effectively used to transform health care delivery.

We thank you for your serious consideration of our thoughts on the proposed rule, and the additional concerns outlined here, and we would welcome a dialog between AMGA's leaders, the Centers for Medicare and Medicaid Services, and the Office of the National Coordinator.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher".

Donald W. Fisher, Ph.D.
President and CEO