ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

September 12, 2013

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW
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Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Department of Health and Human Services
Room 729-D, Hubert H. Humphrey Building
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RE: ACP Concerns with Meaningful Use Program

Secretary Sebelius, Ms. Tavenner, and Dr. Mostashari:

On behalf of the American College of Physicians, I am writing to share our views on what has been released for Stage 2 and what we have been told to expect for Stage 3 of Meaningful Use. ACP is the largest physician specialty society and second-largest physician membership organization in the United States. ACP represents 137,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults.

ACP applauds ONC and CMS, as well as the Health IT Policy Committee and Standards Committee for their diligence and hard work in developing Stage 2 of the EHR Incentive Program. However, we are concerned that the very aggressive timeline combined with overly ambitious objectives may unnecessarily limit the success of the entire EHR Incentive program. Further, the reliance on evolving and draft standards, technologies for which integration is not yet completely tested, developing infrastructure, and upcoming regulatory requirements (i.e., ICD-10) add complexity and uncertainty to the situations faced by physicians and their teams. As you work to transform the recommendations for Stage 3 into ambitious yet broadly achievable measures, we urge you to keep in mind the original guiding principles of the program – to position physicians and other healthcare providers to deliver excellent, patient-centered care focused on improving clinical outcomes. While we support the goals represented by the Meaningful Use (MU) objectives, we are concerned about the appropriateness, focus and feasibility of some of the proposed measures, as well as the potential unintended consequences and additional costs to the practices of these well-intended efforts.

As Meaningful Use has become more prescriptive of certain workflows, it has become less relevant to internal medicine subspecialists. We are concerned that subspecialists may not adopt and fully realize the potential of certified EHR products if the requirements of the program do not allow for the unique workflows required by some subspecialists. In fact, ACP prefers that the requirements become less prescriptive in general to allow eligible professionals of all specialties to be creative in applying the technology to their unique clinical and patient needs.

Stage 2 Time Line Concerns

It is becoming clear that the timeline for successful Meaningful Use reporting in 2014 is in jeopardy. As of August 31, only 15 EHR systems have been certified for the core ambulatory EHR requirements, according to the Certified Health IT Product List (CHPL). No system has been certified for the full set of Meaningful Use requirements. Only four systems have been certified for the recommended adult core Clinical Quality Measures (CQMs). Unless there is a sudden increase in the number of EHRs certified for the full set of MU requirements, it appears that the vast majority of practices are going to have to assemble a full 2014 system from a variety of EHR modules. This will be particularly challenging for smaller practices and those who have already invested significant time, money and effort to implement certified EHR products for Stage 1 of MU. Further, we understand that even vendors who have achieved certification are not yet prepared to implement the new system for all current customers in a timely fashion.

Other groups have also identified these problems and have suggested modifying Stage 2 reporting dates in order to extend the first reporting window for Stage 2. We share those concerns because EPs should not be penalized for problems with vendor or IT readiness. While we do not favor any particular scheme over another, we support the request to extend and/or add flexibility to the initial reporting period for Stage 2.

The implementation of software by a practice does not mean that the practice is prepared to use it appropriately or to make the care process changes needed to accomplish the objectives. Additional time is needed to educate practices in how the Meaningful Use functions can be implemented in ways that improve workflows, improve patient care, and ensure patient safety. Without any change to the date requirements, we believe that most practices which are able to implement 2014 certified EHR technology will attest towards the end of CY 2014 (or later, if extra time is granted for the first reporting window for Stage 2). The result is that only 15-18 months (or less) will be available for the critically important policy, workflow, and cultural changes necessary to successfully implement Stage 2 functionality beyond this initial attestation. This work must be done prior to the beginning of Stage 3 assuming the focus of Stage 3 remains on *improving* outcomes. As such, we further support the extension of Stage 2 by at least one year, and perhaps even longer.

Specific Clinical Quality Measure Concerns

Another growing concern is that the CQM reporting process will not be ready. There has not been sufficient time either for the new e-measures to be tested and validated, or for a determination if the output of the EHR systems is an accurate representation of the performance of the EPs. While it is true that CQMs can be seen primarily as a test of reporting and not of performance, we see this view as not one that is consistent with the overarching goal for clinicians for Stage 2 – which is using, or developing and using advanced clinical processes. The eCQMs all use the HQMF Draft Standard for Trial Use (DSTU) first version, which has been updated for clearer understanding. Work to implement the prior version may require re-work by vendors and practices alike as the new and, as yet untested, version becomes available for subsequent stages of MU. Many efforts for the 2011 MU program included hard wiring of components to report the eCQMs and advance review of the 2014 eCQMs suggests a similar hard wiring is needed to report successfully.

As we also see a key ask of clinicians for Stage 2 is engagement – where engagement includes thoughtful selection of appropriate CQMs AND CDS interventions aimed at improving quality or maintaining high quality – we believe that CQM scores must be accurate enough such that appropriate actions taken to improve quality are reflected. Without this feedback loop, CQM scores may be seen more as random numbers than a consequence of optimized EHR infrastructure and thoughtful care redesign – and this would be disastrous for Stage 3 readiness. A further concern with the CQM reporting requirements is that EPs may not have many options when it comes to choosing the CQMs that they wish to report. Judging by the certification criteria and current reporting in the CHPL, any given vendor is unlikely to stray very far from the smaller subset of recommended adult and pediatric measures.

ICD-10 and PQRS

2014 will be a difficult and frustrating year for physicians and other healthcare professionals no matter what might happen with Stage 2 Meaningful Use. Every practice will be using ICD-10 and will need a new or updated EHR system ready to go on January 1, 2014 in order to meet the data collection requirements for PQRS and combined PQRS/EHR Incentive reporting using e-measures. While actual reporting may not occur until as late as the start of 2015, the proper data elements required to complete reporting must be collected beginning with the first patient on January 1, 2014. The conversion to IDC-10 represents an even larger challenge.

Scoring Meaningful Use Measures

The all-or-none, pass-fail requirement placed on providers attempting to participate in Meaningful Use is counter-productive. Forcing providers to focus solely on achieving particular scores on a broad range of measures prevents them from implementing the innovations that will lead to the achievement of the actual intended goals of improving care and value. Especially as the EHR Incentive Program moves from an incentive phase to a penalty phase, the all-or-none scoring system appears particularly inappropriate. Not every measure is absolutely appropriate and of equal value to every practice situation. Moving to a partial scoring or tiered system in Stage 2, with a higher score required for an incentive and a lower threshold required to avoid a penalty would create a needed element of flexibility to allow practices to choose the measures that matter most to them and dedicate additional time to developing the advanced clinical practices that they will need to achieve improved outcomes. We would be happy to work with you and other stakeholders to develop a detailed proposal for a fair and appropriate scoring system.

Deeming as a Way to Refocus on What's Important And Reduce Unnecessary Burden

As we begin planning for Stage 3 and its focus on improving outcomes, we urge ONC and CMS to keep this goal firmly in-mind. There are better ways for EPs to prepare for and to deliver better outcomes than logging activities that may or may not have direct impact on the quality, safety, or value of care. For example, constructing and delivering a Million Hearts® program would make use of most existing meaningful MU measures. Demonstrating that it is in place and publishing data that show good care or improvement is where EPs should be for Stage 3 – not checking boxes. Maintenance of Certification (MOC) programs, national registries, and other similar programs focus on real improvement of outcomes and cannot be completed satisfactorily without competent use of health IT and expert ability to gather and analyze the clinical data available. To the extent that practices can deliver evidence of safe and high quality care and/or real improvement in outcomes using health IT, there is no need for the EHR Incentive Program to force the practices to perform additional activities that divert them from their focus on real improvement. Rulemaking for Stage 3 should thus begin by assuming that deeming should be a common and preferred pathway for most providers to achieve Stage 3 Meaningful use, and not just an approach for a small number of high performing providers.

Summary

- We support the timetable for 2014 certified technology, as this will keep appropriate pressure on the industry to improve technology, interoperability, and capabilities for enhancing patient engagement.
- We support providing more time for providers to begin their reporting on Stage 2 measures.
- We support additionally extending Stage 2 by at least one year to allow for appropriate time for providers to tackle the real work of Stage 2 – developing and starting to use advanced clinical processes; all of which must occur in Stage 2, if Stage 3's overarching goal is the achievement of improved outcomes.
- We support ongoing efforts to make CQMs better and aligned not just to measuring activity, but improving quality.
- We support de-coupling certification requirements from EP implementation and reporting requirements.
- We support switching to a scoring system that recognizes the differences in practices and the differences between incentives and penalties.
- We encourage a less prescriptive approach to workflow requirements that allows practices to address the unique characteristics of their practice, specialty, and patient population.
- We support Stage 3 rulemaking that is guided by the intent of Meaningful Use and further informed by where most providers should be at that point in their Meaningful Use journey; which is the ability to successfully attest solely by their participation in an appropriate variety of deeming activities, such as participation in Million Hearts®, national registries, or other specified Maintenance of Certification (MOC) programs.

The Medical Informatics Committee of the American College of Physicians respectfully submits this letter hoping that it will assist ONC and CMS in the important work of improving healthcare in the United States through the appropriate use of health information technologies.

Sincerely yours,

Peter Basch, MD, FACP
Chair, Medical Informatics Committee
American College of Physicians