



March 15, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-0033-P, Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule (Vol. 75, No.98), January 13, 2010

Dear Ms. Frizzera:

As the nation's principal voice for medical group practices with 21,500 members managing and leading 13,700 organizations, in which more than 275,000 physicians practice, the Medical Group Management Association (MGMA) is very supportive of physician practice adoption of health information technology (HIT). However, we are very concerned about the direction proposed for the Medicare and Medicaid electronic health record (EHR) incentive program. We believe that if the program logistics and meaningful use requirements proposed in the above entitled rule are not substantially modified, the result could be a failure to meet the goals outlined in the American Recovery and Reinvestment Act of 2009 (ARRA) and a missed opportunity to transition large numbers of medical practices to HIT.

The objective of HIT investments is to improve healthcare quality, control growth in costs, enhance the efficiency of healthcare administration, stimulate innovation, and ensure the privacy and security of patient information. While ARRA sets out broad requirements for the incentive program, it is clear that the overarching goal of the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) should be to develop a robust yet flexible set of supporting regulations. We assert that in order to fulfill the objectives outlined in the underlying legislation, the meaningful use requirements must be achievable and verifiable without creating an undue burden on eligible professionals and their administrative staff. This is especially critical in the first years of the incentive program.

MGMA conducted member research in February to determine the ability of medical groups to meet the "meaningful use" requirements and qualify for EHR incentives. The more than 445 respondents were asked a series of questions that included their plans to participate in the incentive program, their reaction to the proposed meaningful use criteria, and their opinion of the impact on practice productivity

should they implement the 25 proposed criteria. We will be incorporating the results from that research in this document.

We offer the following recommendations to assist in the development of a program that promotes widespread adoption of EHRs and furthers the development of a national HIT structure that will best meet the needs of a very complex and diverse healthcare system.

Below is a summary of key concerns and recommendations. A more detailed explanation follows.

- **Adhere to the Intent of ARRA**

It is critical that CMS and ONC carefully reconsider the proposed meaningful use definition and program requirements before crafting a final rule. We believe it is imperative to remember that the intent of ARRA was to provide a practical and achievable glide path to enable large numbers of physicians and other providers to adopt EHRs. We do not believe that the legislation anticipated the onerous nature of the proposed meaningful use criteria nor the expected high cost and decreased physician productivity associated with participation in this incentive program.

- **Identify a Practical and Achievable Set of Measures**

We recommend that for Stage 1 of the program, CMS replace its proposed, highly demanding meaningful use objectives and measures and very aggressive timelines with a set of practical and achievable baseline measures that will be applicable to the multitude of medical specialties, provider types, and clinical settings.

- **Eliminate a Number of Meaningful Use Objectives and Measures from Stage 1**

There are a number of meaningful use objectives and measures that should not be included in Stage 1 of the incentive program. These include:

- Checking insurance eligibility electronically for at least 80 percent of all patients
- Filing 80 percent of all claims electronically
- Providing timely access to patients' health information for at least 10 percent of patients
- Performing one test of EHR's capacity to electronically exchange key clinical information
- Performing medication reconciliation
- Testing EHRs capacity of submit electronic data to immunization registries and syndromic surveillance data to public health agencies
- Conducting or reviewing a security risk analysis

- **Modify the Hospital-Based Provider Definition**

The definition of a hospital-based provider excludes many eligible professionals who practice in hospital settings from qualifying for the incentives. This broad definition could, using CMS estimates, exclude as many as 27 percent of otherwise eligible professionals from the incentive program. The definition could be simplified by determining if the eligible professional utilizes an inpatient or ambulatory EHR. If the latter, they would be eligible for the incentives.

- **Extend Stage 1 through 2013**

CMS is urged to request legislation extending Stage 1 of the program to 2013. Stage 2 of the program could begin in 2014, and 2016 could be the start year for Stage 3 of the program. Penalties would not begin until 2016 under this recommended approach. This would yield additional and necessary time for the software to be developed, certified by the vendors, and implemented and tested in physician practices.

- **Develop Workable and Flexible Program Logistics**

In order to incentivize large numbers of eligible professionals, the incentive program should be designed to minimize the burden of data collection, data reporting, and compliance attestation. CMS should develop a pre-test process for program participants to ensure they are collecting and reporting data properly before they begin the program. In addition, rather than develop the program with a simple “pass/fail” structure, we recommend that eligible professionals be required to meet 25 percent of the meaningful use criteria in Stage 1.

- **Revise the Clinical Quality Measures**

We ask that CMS substantially reduce the number of quality measures, focusing on those measures that have validated EHR specifications, are selected from other quality measurement and reporting programs, and have data requirements for the measure available within EHRs. MGMA recommends that CMS and ONC provide: (a) interim feedback to participating medical practices so practices can check and make corrections to their reporting practices; (b) a minimum of a one year delay in the quality reporting requirement; (c) greater flexibility for providers to select which quality measures are clinically relevant for their practice to report; and (d) offer a non-punitive opportunity for medical practices to test the functionalities of their EHRs to collect and submit the numerators, denominators, and exception codes associated with clinical quality measures.

- **Develop a Certification Process that Assists Practices Select Appropriate Software**

In order to provide eligible professionals with the tools necessary to select the most appropriate EHR for their organization, we recommend that the certification process provide eligible professionals with more than just the assurance that their software meets the minimum requirements for program eligibility.

- **Grandfather in Current CCHIT Certified EHRs**

In recognition of the severe time constraints on EHR software developers, certification entities, and eligible professionals themselves, we recommend that all EHR products that are certified by the Certification Commission for Health Information Technology (CCHIT) at the 2008 certification level or later be deemed as meeting the Stage 1 meaningful use certification requirement.

- **Monitor the Industry**

ONC should aggressively and comprehensively monitor the industry to ensure: (a) sufficient certified EHR products meet the needs of all segments of eligible professionals; (b) that marketplace bottlenecks and product order backlogs caused by delayed software development and/or a protracted certification process are not preventing eligible professionals from obtaining and implementing appropriate products in a timely manner; and (c) that product pricing is not preventing large numbers of eligible professionals from participating in the incentive program.

General Comments and Recommendations

1. **Eligibility for the Medicare incentive program.** We believe that the overly broad definition of a hospital-based eligible professional will inappropriately exclude those eligible professionals who practice in outpatient centers and clinics from HIT incentive payments merely because they provide patient care in an office or clinic that is located in a facility owned by a hospital or in the hospital itself. The definition of hospital-based providers is very narrow and excludes a large number of ancillary providers that are hospital affiliated.

CMS proposes to define a hospital-based eligible professional as one who furnishes 90 percent or more of his or her covered professional services in the calendar year preceding the payment year in a hospital setting. A hospital setting is identified by the place of service codes used in the HIPAA standard transactions that identifies the site of service as an inpatient hospital, outpatient hospital, or emergency room. Under this definition, a significant percentage of eligible professionals will be ineligible for Medicare or Medicaid incentives, well beyond those typically considered hospital-based eligible professionals or what Congress anticipated in the examples explicitly stated in ARRA.

In the proposed rule, CMS projects that 27 percent of eligible professionals will be excluded from participating in the incentive program as being hospital-based providers. It appears that the drafters expected that hospitals would provide EHR services for affiliated practitioners, but in today's environment, this is not so. There are also a significant number of state laws that prevent hospitals from providing such services to affiliated practitioners.

In many instances, outpatient-focused eligible professionals, even if practicing in a site classified as a hospital outpatient site by the place of service code, are either not using the hospital EHR or are using a system that is heavily customized for ambulatory use. These typically will require separate and additional implementation, services, and support. Just as ARRA permits incentives to eligible professionals in a hospital-owned practice located away from the hospital campus, so too should it permit payment for a separate ambulatory-focused EHR, even if it is paid for in whole or in part by the hospital.

Should this issue not be resolved, we anticipate that the EHR incentives will not reach nearly one-third of eligible professionals. Since many less affluent patients go to hospital clinics instead of private practices, this policy will create a wider digital divide, increasing healthcare disparities.

Recommendations:

1.1 - CMS should adopt a broader definition of hospital-based eligible professionals, consistent with the ARRA statutory language and congressional intent. In particular, we urge that, since this category of

provider was defined in ARRA, CMS should consider the type of certified EHR that the eligible professional is using in addition to the place of service code. A hospital-based eligible professional should be defined as one who provides 90 percent of their services, defined as encounters and not as charges in a hospital setting, and that they also use the hospital inpatient certified EHR to support the care they are providing in this setting. This approach would permit physicians to be considered “eligible professionals” if they used a certified ambulatory EHR and not hospital-based providers. Eligible professionals, as part of their attestation process, should attest that they are not hospital-based eligible professionals as per the proposed new definition above.

2. **Eligibility for Medicaid incentives.** We are concerned that Medicaid providers who service patients from several states may not meet the 30 percent patient threshold requirements in any one state. In addition, eligible professionals that work in a rural environment may not reach the percentage threshold, but may still serve a significant number of state Medicaid patients.

Recommendations:

2.1- Medicaid providers should be permitted to aggregate their patient base across all states in which they participate with Medicaid to meet the percentage requirements.

2.2 - We recommend reducing the percentage threshold that must be met to receive the Medicaid incentives to 20 percent and that the threshold for pediatricians be reduced to 10 percent. This would not only expand the program to incentivize a larger number of eligible professionals to be meaningful users of EHRs but would potentially expand the clinical services available to the Medicaid patient population.

3. **Incentive program stages and program design.** The proposed rule outlines a three stage process of meaningful use requirements under the Medicare incentive program. CMS proposes Stage 1 to be calendar years (CYs) 2011 and 2012; Stage 2 to be CYs 2013 and 2014; and Stage 3 to be CY 2015 and beyond. The proposed rule specifies 25 EHR objectives that must all be met by eligible professionals in order to be considered meaningful users and receive incentive payments in Stage 1. CMS has also indicated plans to increase the meaningful use requirements for Stages 2 and 3.

Practice administrators report that the proposed staged approach does not correspond with the typical pace at which implementation of complex EHR systems is completed. Industry experience suggests that EHR adoption is a multi-year, incremental process that requires significant capital and operating expenditures, investment in human capital, and close collaboration between clinical and other practice staff. This approach typically requires at least a one-

year window from the initial project conceptualization to the point where clinicians are actually using the systems for patient care.

The 100 percent compliance requirement, or in other words the “all or nothing” approach proposed in the NPRM is unacceptable and will lead to widespread program failure. Failing to meet even one threshold of one measure would cause the eligible professional to be excluded from the incentive program for that reporting period. This concern alone will act as a significant deterrent to physician practice participation in the program.

To ensure that meaningful use can be successfully adopted in a wide range of practice settings, including small and rural physician practices, it is important to review the approach taken in the government’s current electronic prescribing rulemaking process. In that case, the HHS Secretary must pilot test any electronic prescribing national standard if there is not wide industry experience with that standard.

Recommendations:

3.1 - While MGMA agrees that a “staged” approach permits flexibility in meeting the meaningful use objectives, it is critical that the bar for meeting the meaningful use requirements not be set overly high, especially for Stage 1. We recommend that the approach taken in the proposed rule for reduced requirements for the initial year of the Medicaid incentive program be applied to eligible professionals seeking to qualify under the Medicare incentive program.

3.2 - The Stage 2 and Stage 3 meaningful use criteria should not impose onerous new measures on eligible professionals.

3.3 - There should be flexibility provided to the eligible professional in meeting the requirements of the program. Rather than develop the program with a simplistic “pass/fail” structure, we recommend that physicians be given a “progress report” on their meaningful use achievement and sufficient time to restructure/modify their systems and submit corrected data to achieve full meaningful use during a particular reporting period. A phased approach could also incorporate a system where eligible professionals would be considered meaningful users by meeting fewer requirements in the early years of the program, but building toward achieving an increasing set of meaningful use objectives over time. We recommend the following approach:

- **Stage 1 – Meet at least 25 percent of the objectives;**
- **Stage 2 – Meet at least 50 percent of the objectives; and**
- **Stage 3 – Meet at least 75 percent of the objectives.**

3.5 - CMS should permit eligible professionals to self-select the objectives they meet, with the understanding that certain “core” measures may be required if they apply to the eligible professional’s specialty and care setting.

3.6 - The overall number of meaningful use requirements for eligible professionals should be decreased. (See our comments on the specific objectives and measures for a discussion of those criteria we believe should be removed from the incentive program.)

3.7 - CMS should ensure that objectives and measures selected for Stage 1 should be functionalities that are already in widespread use. Those that are not in widespread use should be pilot-tested in an expedited manner prior to being required in future stages. It is critical to avoid imposing criteria that do not have widespread experience. This will be especially important in the small and rural clinical settings.

3.8 - As the meaningful use requirements are modified for subsequent stages, CMS should provide a minimum transition period of 24 months from the point when EHR software products certified to meet new requirements are generally available from the time to when certification is required for incentive payments.

- 4. No threshold or numerator requirements for Stage 1.** The proposed rule relies heavily on threshold requirements for a number of the meaningful use measures. There is little or no supporting evidence presented in the proposed rule justifying these thresholds. As a result, we expect a significant percentage of eligible professionals will fail to meet the program requirements due to these arbitrarily high thresholds.

Recommendations:

4.1 - For Stage 1 of the incentive program, the meaningful use measures should not require the eligible professional to capture numerators. Rather, eligible professionals should attest to having the capability of meeting a particular measure and report, where applicable in their specialty and clinical setting, all instances (denominators). For example, an eligible provider would report the number of instances a particular measure was met, such as the number of times they were able to prescribe electronically or the number of orders they entered electronically into their EHR. This would reduce the data collection and reporting burden on eligible professionals; while at the same time provide an important benchmark for the potential development of thresholds for future stages of the program.

4.2 – Should CMS decide in the final program specifications to list a core set of objectives and measures that all eligible professionals would be required to meet, we strongly urge that a denominator of zero be permitted. Thus, if

electronic prescribing is a required measure, those eligible professionals who do not prescribe in their normal course of patient care should not be deemed ineligible simply because their denominator was zero.

5. **Certification.** We believe that EHR certification is one of the critical foundations for rapid adoption of this technology in the ambulatory setting and a key component of the incentive program. ARRA stipulates that in order to be a meaningful user, an eligible professional must be using a “certified” system, but it does not delineate any specifics regarding the nature of that certification. The release of the NPRM on certification earlier this month seems to indicate that ONC is moving toward the development of an entirely new approach to the certification of EHRs and modular components. With such a short time frame between the release of the final program specifications and the start date for the program, we are very concerned that eligible professionals will not be afforded the time necessary to select and fully implement a certified system under this proposed approach.

CCHIT has been certifying EHR software in ambulatory settings since 2006. The strong CCHIT brand name has resulted not only in increased buying confidence on the part of physician practices, but has also led to an increased level of standardized product development by vendors. Physician practices are familiar with the CCHIT brand and have incorporated CCHIT certification into their core set of purchasing deliberations. CCHIT certification tests functionality, interoperability, and security capabilities far beyond the meaningful use requirements. Should numerous private entities be permitted to certify full EHRs or individual modules strictly on meeting the meaningful use requirements, we are concerned that practices will rely on this certification as a benchmark for overall EHR performance. This, in turn, could lead to inappropriate software selection and failed installations.

In National HIT Coordinator, Dr. David Blumenthal’s *New England Journal of Medicine* article, “Stimulating the Adoption of Health Information Technology” (Vol. 360: 1477-1479, Apr. 9, 2009), it is accurately stated that many certified EHRs “are neither user-friendly nor designed to meet [ARRA’s] ambitious goal of improving quality and efficiency in the healthcare system.” This user-friendliness issue is critical in terms of the successful transition of the nation’s physician practices to EHRs. Simply put, if the EHR technology does not permit easy installation and utilization, many of the purported benefits will be achieved more slowly, if at all.

Once the program rules are finalized, the federal process to accredit certification agencies must still be established, and certification entities must be approved. Those administrative steps only set the infrastructure for certification. EHR vendors must design or revise their software, certify them through this new federal process, and then bring them to market. Given these numerous and complex steps, it seems unlikely that a wide array of certified systems will be available before January 2011. ONC itself in the rule estimates that “it will generally take 6 to 18 months for commercial vendors and open source

developers...to prepare for testing and certification” (*Federal Register*, Vol. 75, No. 8, p. 2041).

In addition, we contend that the 2011 start date for the incentive program precludes the development and deployment of significant additions to the criteria required for certification. The process for a physician practice to identify, contract and purchase, implement, train staff, and conduct internal and external testing takes on average one to two years. Any attempt to add significant program requirements that are not currently required in CCHIT certification will most likely lead to delayed software development resulting in eligible professionals being unable to qualify for the incentives until well after 2011.

Recommendations:

5.1 - In order to provide eligible professionals with the tools necessary to select the most appropriate EHR for their organization, we encourage the certification process provide physicians with more than just the assurance that their software meets the minimum requirements for program eligibility.

5.2 - In addition to supporting CCHIT’s current certification agenda, we recommend that this organization and any other appropriate entities receive additional federal funding to incorporate usability criteria into its testing criteria.

5.3 - In recognition of the severe time constraints on EHR software developers, certification entities, and the eligible professionals themselves, we recommend that all EHR products that are CCHIT certified at the 2008 certification level or later be deemed as meeting the Stage 1 meaningful use certification requirement.

6. **Demonstration of meaningful use.** Creating a process that is effective yet simple for physician practices to attest to meeting the meaningful use requirements will be a critical component of a successful incentive program. This will be particularly important in the initial stage of the program and could be verified through an audit process. The development of a complicated and time-consuming process for practices to prove that they meet the incentive qualifications will result in fewer organizations participating in the program.

Recommendation:

6.1 - We recommend that attestation and/or survey instruments serve as the primary methods of meaningful use demonstration for Stage 1 of the incentive program.

7. **Avoid reliance on third party compliance.** Having eligible professionals forced to rely on the actions of third parties in order to meet meaningful use requirements will result in some eligible professionals failing to qualify for the

incentives, even though they may have demonstrated the capability to meet the requirements. An example of this is the measure that requires that “at least 75 percent of all permissible prescriptions written by the eligible professional are transmitted electronically using certified EHR technology.” To reach this high threshold, eligible professionals will, for example, be forced to rely on pharmacies being able to receive electronic prescriptions and patients accepting electronic prescriptions. We believe it would be unfair for an eligible professional to be disqualified from program participation because of actions or inactions taken by others.

Recommendations:

7.1 - Meaningful use measures should not require the eligible professional to rely on the capabilities, actions, or inactions of other entities in order to meet the minimum requirements. This would potentially include the capabilities, actions, or inactions of pharmacies, laboratories, or even patients themselves.

7.2 - For Stage 1 of the incentive program, meaningful use measures should not rely on arbitrary thresholds, but rather should be crafted to focus on “capability.”

8. **Program logistics** - Similar to other Medicare incentive programs, the success or failure of the incentive program will be dependent on the logistics of the program. The more providers are presented with significant challenges in the collection and reporting of data, the higher the likelihood of failure.

Since many physician practices plan to leverage their expected incentive payments in their EHR contracting process, they need assurances that they will qualify for the incentives prior to their purchase. Should they not receive these types of assurances, many may choose not to participate in the incentive program.

Large numbers of practices participating in the Physicians Quality Reporting Initiative (PQRI) discovered after the program ended for the year that they did not qualify for the incentive payments. Should the EHR incentive program be administered in a similar fashion, eligible professionals that experience problems with meeting the requirements could miss out on two years of incentive payments. For example, if an eligible professional elects to report in the last reporting period in 2011 (October through December) and for the full year in 2012, yet finds out during 2012 that due to unforeseen problems they failed to qualify in 2011, they will miss out on the incentive while still incurring the cost to collect and report data.

Recommendations:

8.1 – CMS and ONC should issue the logistics of the incentive program as

quickly as possible and permit public comment. Issues to be covered should include:

- (a) Process to apply for the meaningful use program;
- (b) Process to receive payments;
- (c) Process to submit meaningful use data;
- (d) Information required for attestation;
- (e) Process to appeal
- (f) Process for self-certification; and
- (g) Any additional program requirements.

8.2 – CMS and ONC should provide expedited feedback on missing or incomplete data to eligible professionals. This would allow an eligible professional to rectify the problem and re-submit their data, attestation, or other missing or inaccurate information.

8.3 - There should be an appeals process developed as part of the incentive program. This appeals process should permit eligible professionals who failed to qualify during the reporting period to either prove that they had met the requirements or be provided additional time to correct the problem and resubmit the required data or information. In either case, these eligible professionals should qualify for that year's incentive payment.

8.4 - CMS should provide eligible professionals the right to petition for a change in their hospital-based status when there is a material change in their organizational affiliation (i.e., a physician leaving a hospital-based practice to join an outpatient physician practice).

8.5 - CMS should implement a similar appeals process for the Medicare program as the one it proposes to implement for the Medicaid incentive program.

8.6 - Eligible professionals who experience data collection or reporting problems that make them ineligible for a particular year's incentive payment should be permitted to participate in the next year's reporting period without penalty and at the previous year's payment rate, providing they meet the meaningful use requirements for that previous year.

9. **Program support** – It is critical that eligible professionals avoid encountering problems during the meaningful use reporting process.

Recommendations:

9.1 - CMS should make their "hospital-based" determinations, and expeditiously notify professionals of their status before the start of each physician payment year, beginning with calendar year 2011. Should CMS fail to do this, there is the potential that eligible professionals will register

for EHR incentive payments and begin the burdensome and costly collection and reporting process, only to find out at a later date they are hospital-based and not eligible for payments in the first place.

9.2 - CMS should ensure timely responses to eligible professionals once their data have been submitted in support of their meaningful use reporting requirements.

9.3 – CMS and ONC should be ready to accept meaningful use data in late 2010 in order for physicians to send test data, receive feedback from an appropriate government agency, and have sufficient time to take appropriate actions to modify their system should they encounter data content or transmission problems.

9.4 - The process for physicians to demonstrate that they have achieved meaningful use should be simple and flexible enough so that physicians in all types of clinical settings can attest their compliance with the requirements. We strongly encourage that self-attestation be the primary attestation approach adopted. In addition, third party attestation should also be considered, much like current physician use of the data registries for PQRI reporting.

10. **Reporting period** - We are supportive of the proposed 90-day reporting window for the first year of the incentive, although we assert that this reporting window length should be replicated for the remainder of the program. Eligible physician reporting will be an onerous task, regardless of the length of time required for that reporting. Data on the myriad of meaningful use measures will require significant resources to capture and report. This issue will be exacerbated should the eligible professional select to integrate a modular approach to meeting the meaningful use requirements. Streamlining of these requirements coupled with a reasonable timeframe is far more likely to achieve the outcome desired from the legislation - widespread adoption of EHRs. Conversely, requiring reporting for the entire year may act as a deterrent for physician practice adoption of EHRs due to the cost of collecting and reporting, and the increased chance that a particular measure or threshold will not be achieved (even for a short period), thus making the physician ineligible for that year's entire incentive payment.

Recommendations:

10.1 - We support the proposed multiple 90-day reporting windows for the first year of the program and strongly encourage the extension of these multiple 90-day reporting windows throughout the calendar year for the entire incentive program.

10.2 - We recommend that CMS encourage eligible professionals to submit meaningful use data throughout the year, but leave this reporting approach optional.

10.3 - Eligible professionals should be provided multiple methods of submitting meaningful use data. Similar to that permitted under the PQRI, eligible professionals should be able, if required, to submit data in Stage 1 of the program using claims, registries, or directly from their EHR.

- 11. Full definitions required for critical terms** - Many of the proposed meaningful use measures include requirements predicated on specific terms. These terms must be explained clearly in the final rule to ensure no ambiguity and to provide clear direction for eligible professionals seeking to meet the meaningful use requirements.

Recommendation:

11.1 – The language detailing the meaningful use objectives must be precise and all terms related to the measures must be clearly defined. These terms include, but are not limited to “unique patient,” “order entry,” “health information,” “48 hours,” and “structured data.”

- 12. Pre-testing and pre-qualification of EHR software**. Successful participation in the Medicare and Medicaid EHR incentive program will require eligible professionals to make a significant and upfront financial investment. To protect this investment, a mechanism must be offered by the government to allow practices to occasionally check their participating threshold status and success. Many practices participating in the PQRI discovered after the program had ended for the year that they did not qualify for the incentive payments.

Low success rates associated with the PQRI prove there is a considerable need for all reporting programs to provide timely and actionable feedback. In the case in the EHR incentive program, this type of interim feedback will be critical to medical practices' willingness to purchase EHRs and therefore attempt participation in this new incentive program. Through timely feedback, practices will have the opportunity to correct their reporting processes during the reporting period. In contrast to current PQRI provider experience, eligible professionals participating in the EHR incentive program must be assured that data transmissions are working as intended at the onset of the process.

Recommendation:

12.1 – CMS and ONC should institute a process to test systems prior to the eligible professional “going live.” We recommend that the government develop a process where physician practices could submit their software specifications and test their quality data reporting methodology and receive timely and actionable feedback regarding their ability to qualify for the incentive payments. This “pre-testing” should be web-based and provided

to the eligible professional or their designated staff.

13. Simplify the reporting process. Quality reporting is a central element of meaningful use. Allowing practices of varying sophistication the ability in Stage 1 to report their quality data utilizing various methodologies (i.e., claims-based, data registries, and summary clinical data transmitted directly via the EHR) will ensure that as broad a group of practices as possible will have the ability to move forward with adoption of HIT, successfully report quality measures and qualify for the incentives. In addition, it is critical that this reporting requirement take into account current reporting programs to avoid duplicative efforts.

Recommendation:

13.1 - The government should simplify the reporting process for Stage 1 and allow practices with varying technical capabilities the ability to report meaningful use data utilizing various methodologies (i.e., claims-based, data registries, and summary clinical data transmitted directly via the EHR). This will ensure that as broad a group of practices as possible will have the ability to move forward with adoption of HIT, successful reporting of quality data, and qualify for the incentives. In addition, it is critical that this reporting requirement take into account current reporting programs to avoid duplicative efforts.

14. Module approach to meeting the meaningful use requirements. CMS proposes to use the certification definitions in the companion Interim Final Rule on standards and certification criteria (p.1992). This IFR sets out a modular approach to certification. On page 2043, the IFR defines a module as “any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary.” The IFR goes on to indicate that it is the responsibility of the eligible professional or eligible hospital to perform due diligence to ensure that the selected certified EHR modules are capable of working together to support achievement of meaningful use, and that eligible professionals should take care to ensure that the certified EHR modules they select are interoperable and can properly perform in their expected operational environment.

Recommendation:

14.1 - We are concerned about individual modules from multiple vendors having the ability to integrate effectively to support meaningful use and to achieve the functional equivalence of a complete EHR. We recommend that eligible professionals receive specific guidance from CMS and ONC on how they are to utilize the modular approach to certified EHR technology.

15. Unintended consequences of rapid adoption. Should ambulatory providers

rush their implementation of an EHR in order to meet the incentive program requirements, there is the risk of failed implementations, missed opportunities to improve workflows and create sustainable change, and potential risks to patient safety.

Recommendation:

15.1 - MGMA urges CMS to consider the potential unintended consequences of the very aggressive timeline for EHR implementation it has proposed. To avoid the problems described above, practices will require sufficient time to test their EHR systems to ensure that the system is appropriately configured and that all safeguards are in place to avoid patient harm.

15.2 – MGMA urges CMS to seek legislation extending Stage 1 of the program to 2013. Stage 2 of the program could begin in 2014 and 2016 could be the start year for Stage 3 of the program. Penalties would not begin until 2016 under this recommended approach. This would yield additional and necessary time for the software to be developed, certified by the vendors and implemented and tested in physician practices.

16. Recognition of the Impact of other Federal Mandates. There are numerous current and pending regulatory mandates impacting physician practices. Compliance with these initiatives will be competing with the EHR incentive program for practice resources.

Recommendation:

16.1 – In developing objectives, measures and program timelines, CMS should recognize the additional challenges facing eligible professionals in the coming months which will draw on the same resources necessary to meet the EHR incentive program requirements, notably the shift to the 5010 version of the HIPAA electronic transaction standards, the transition to ICD-10, new Privacy and Security and Red Flag regulations, and other potential changes related to healthcare reform legislation.

17. Monitoring of the EHR marketplace – Section 3007 (a) of the ARRA legislation states that the “National Coordinator shall support the development and routine updating of qualified electronic health record technology (as defined in section 3000) consistent with subsections (b) and (c), and make available such qualified electronic health record technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace.”

We encourage the close monitoring of the EHR marketplace by ONC to ensure that appropriate and cost-efficient products are being offered in a timely manner to physician practices, especially small practices with limited financial resources. We also encourage the early recognition by the ONC of marketplace failures and the subsequent requirement for the deployment of low-cost alternative software.

Recommendations:

17.1 - **ONC should aggressively and comprehensively monitor the industry to ensure: (a) that there are sufficient certified EHR products to meet the needs of all segments of the eligible professional industry; (b) that bottlenecks and order backlogs caused by delayed software development or certification are not preventing eligible professionals from obtaining and implementing appropriate products in a timely manner; and (c) that product pricing is not preventing large numbers of eligible professionals from participating in the incentive program, thus triggering the ARRA provision requiring the HHS Secretary to develop alternative products.**

17.2 - **In addition to monitoring the provider sector of the industry, we strongly encourage HHS to oversee the ability of the vendor community to meet the demands of the market. If the ARRA incentive program is viewed in a positive manner by the majority of physicians, there will be a significant surge in the number of practices seeking to purchase and install EHRs. This raises the specter of potentially lengthy queues for installations, hasty installations that result in sub-optimum clinical performance, insufficient maintenance, upgrades, customization, help-desk availability, and the possibility of unfair business practices.**

17.3 - **We urge HHS to aggressively scrutinize the EHR vendor sector, establishing toll-free telephone numbers and a website allowing physician practices and others to report problems, issues, and unfair business practices.**

18. Workflow transformation assistance. There are very real and practical implications of trying to move thousands of physician practices to EHRs in a relatively short timeframe. Practice workflow must be modified in order for this transformation to occur relatively quickly and with minimal disruption to both the clinical and business sides of the practice. It is clear that practices will need assistance to (a) initiate a project management team and review federal and state incentive requirements; (b) select the appropriate software, hardware, connectivity support, etc; (c) redesign their business processes; (d) modify their workflow; (e) successfully install and modify the product to suit the clinical and administrative requirements; and (f) maintain the system and ensure that they continue to meet the minimum federal and state incentive requirements as well as all other applicable laws and regulations .

MGMA research has identified that EHR failure rates are often due to (a) poor project management, (b) inappropriate product selection, (c) inadequate staff training, (d) insufficient/inappropriate infrastructure (i.e., provider-patient interface, memory, connectivity speed), and/or (e) inadequate interface between clinical and administrative data (EHR versus practice management system).

Recommendation:

18.1 - The issues surrounding the need for workflow transformation must be addressed in the broader incentive program. ONC should direct the regional extension centers to develop and disseminate assistance for physician practices focused on the technical and administrative issues stemming from workflow modification.

19. Increased physician practice committee representation. The committees that have shaped the design of the incentive program and driven the development of the meaningful use criteria have not included sufficient representation from the small and medium-sized physician practice community. This representation is critical as professionals in these types of clinical settings comprise the vast majority of the targeted recipients. In order to adequately advise the program developers to identify appropriate requirements for the forthcoming stages, it will be important to create at least one additional workgroup, with representation from a broad array of healthcare professionals with both clinical and administrative expertise.

Recommendations:

19.1 - All relevant committees that support ONC and CMS in the development of policy related to the Medicare and Medicaid EHR incentive program should include significant representation from the small and medium-sized physician practice community.

19.2 - A workgroup with significant representation from eligible professionals from a broad array of clinical settings should be established to provide ongoing program feedback and recommendations.

20. Physician Practice communication and education. The success of the ARRA incentive program will rely in part on effective outreach to the physician practice community. Timelines, definitions, program modifications, updates, and the application processes all must be communicated directly to the potential incentive recipients.

Recommendation:

20.1 - We recommend that HHS develop a multi-pronged communication process that includes, but is not limited to:

- **An easy-to-navigate website with a comprehensive FAQ section.**
- **Toll-free telephone numbers to provide accurate information.**
- **Regularly-scheduled “open door” webinars to provide updates and address participant questions.**
- **Participation by HHS officials at industry conferences and forums.**
- **Direct outreach to provider professional associations.**

Comments and Recommendations Regarding the Objectives and Measures

Proposal:

Eligible Professional Objective 1: *Use Computerized Provider Order Entry (CPOE).*

Eligible Professional Measure 1: *CPOE is used for at least 80 percent of all orders (e.g., medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services).*

Comment:

The recent study “Electronic Health Records in Ambulatory Care – A National Survey of Physicians,” reported in the *New England Journal of Medicine* (Vol. 359: 50-60, July 3, 2008, Number 1); found that only four percent of physician practices reported use of CPOE. We assert that the proposed threshold of 80 percent CPOE usage will not only disqualify a large percentage of eligible professionals from the incentive program, but could also discourage clinicians from purchasing and adopting EHRs. Introducing CPOE into the physician practice setting too rapidly will create duplicative work for physicians, risk diminished physician-patient communication, and may pose patient safety concerns. CMS has proposed to define CPOE as “entailing the provider’s use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.” We believe this measure requires additional clarification.

As for medications, while CMS states under this measure that such orders are not required to be exchanged electronically, the agency states under a separate measure (see measure 4 below) that eligible professionals are required to transmit electronically at least 75 percent of their permissible prescriptions (non-controlled substances). Since prescriptions are a type of order, these two measure requirements are in direct conflict. It is also important for CMS to clarify that the term “medications” under the CPOE context means physician-administered drugs. Other operational definitions are required for terms used in this measure. Without clear and unambiguous definitions for clinical terms such as, “order,” “test,” and “result,” it will be impossible for practices taking part in these incentive programs to report consistent information.

Moreover, it is important to keep in mind that today there is a lack of standardization of laboratory data and no standard way that a laboratory transmits results based on an order from an EHR. Very few physicians today are using CPOE in their offices largely because there are very few entities with which they can exchange data.

We are also concerned with the burden of counting paper orders and other orders

that are not included in the EHR. Requiring physicians to enter 80 percent of all orders into EHRs will require eligible professionals to expend significant time and resources to manually gather information that spans both electronic and paper-based systems. For example, in the case of referrals, it is typical for specialists and independent labs to require their own paper form to be completed by the referring/ordering physician. Therefore, entering the order electronically through CPOE would need to be followed with a manual process involving a paper form. Furthermore, decision support for ambulatory EHRs is still very basic. Until there is a bi-directional exchange of data and robust decision support, we do not believe the value of CPOE can be fully realized just through manual entry of most orders.

Recommendation:

1.1 - For Stage 1, CMS should replace the proposed 80 percent threshold for CPOE with the requirement that eligible professionals attest to having the capability of CPOE and report, where applicable to their specialty and clinical setting, their usage of CPOE.

1.2 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 2: *Implement drug-drug, drug-allergy, drug formulary checks.*

Eligible Professional Measure 2: *Eligible Professional has enabled this functionality.*

Comments:

MGMA supports the proposed objective and measure that requires eligible professionals to attest to enabling the functionality of their certified EHRs to allow for drug-drug, drug-allergy, and drug formulary checks. For Stage 1 of the incentive program, we believe it is critical that no threshold be assigned to this measure. Not all providers with EHRs currently have the technology to implement drug-drug, drug-allergy, and drug formulary checks. This is particularly evident with some of the specialties in which no direct patient contact occurs.

Recommendations:

2.1 - CMS should continue to require only that eligible professionals attest to having the capability to conduct drug-drug, drug-allergy, drug formulary checks.

2.2 - CMS should take the appropriate steps to require health plans and pharmacy benefit managers (PBMs) to ensure that drug formulary information

provided to eligible professionals is accurate and available in real-time.

2.3 - CMS should review the applicability of this measure to all medical specialties, with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 3: *Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®.*

Eligible Professional Measure 3: *At least 80 percent of all unique patients seen by the Eligible Professional have at least one entry or an indication of none recorded as structured data.*

Comment:

We are supportive of eligible professionals' maintenance of an up-to-date problem list of current and active diagnoses. However, we do not support the 80 percent threshold requirement for Stage 1. In terms of the data entry required for meeting the specific measure, the measure as written is - on its face - an unrealistic expectation, especially if every physician in the stream of care needs to gather the same information.

Recommendations:

3.1 - We recommend removing the 80 percent threshold requirement from the measure in Stage 1. We believe that eligible professionals should be required to attest to having the capability of maintaining an up-to-date problem list and report, where applicable to their specialty and clinical setting, their usage of these up-to-date problem lists.

3.2 - CMS should more explicitly define the term "up-to-date" for all incentive program participants, paying particular attention to the differences between the inpatient and outpatient settings.

3.2 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professionals Objective 4: *Generate and transmit permissible prescriptions electronically (eRx).*

Eligible Professionals Measure 4: *At least 75 percent of all permissible prescriptions written by the Eligible Professional are transmitted electronically using certified EHR technology.*

Comment:

We are strong proponents of the use of electronic prescribing in ambulatory settings and support the objective for generating and transmitting permissible prescriptions electronically. However, we believe that the 75 percent threshold requirement for Stage 1 will be extremely challenging for eligible providers to meet. Should this threshold be included in the final rule, we believe that a significant percentage of eligible providers will be unable to meet this threshold and for others it will act as a deterrent from adopting an EHR.

It is important to remember that there are numerous potential contributing factors as to why a clinician who has the capability of transmitting a prescription electronically would be unable to conduct the transaction. These include:

- Technical failure at the transmission site
- Technical failure at the receiving site
- Pharmacy incapable of receiving an electronic prescription
- Patient unwillingness to have their prescription sent electronically
- Patient indecision as to whether or not to fill their prescription at a local pharmacy or utilize a mail order process that requires a mailed or faxed prescription
- Patient wishing to delay the filling of the prescription for financial reasons (i.e., concern regarding minimizing or avoiding the Medicare “donut hole”)
- Patient not having a relationship with a pharmacy
- Patient is visiting the area and will have to establish a relationship with a pharmacy
- Patient will be traveling and will have to establish a relationship with another pharmacy
- Clinician writing a prescription, but informs patient to “fill only if needed”

The eligible professional could encounter some or all of the above barriers, potentially preventing them from achieving the 75 percent threshold proposed for Stage 1 meaningful use criteria. In addition, other barriers exist to the widespread use of electronic prescribing. Several critical electronic prescribing standards have not been finalized (e.g., prior authorization, structured and codified SIG, clinical terminology). Clinicians are also hampered by the fact that controlled substances currently cannot be prescribed electronically. This forces the practice to maintain two separate processes, creating another deterrent to clinician adoption of this technology.

We also believe that the proposed denominator for e-prescribing to count every “permissible” prescription ordered during the reporting period will be too onerous to calculate because prescriptions will continue to be prepared in a variety of ways—electronically transmitted, phoned-in, faxed, and written due to patient preferences and existing laws. In several states, laws and regulations permit e-prescribing of non-controlled substances but they are contradicted by state Medicaid requirements that require paper prescriptions. For example, in Rhode Island, pharmacy regulations allow e-prescribing but state Medicaid regulations require that physicians prescribe drugs for these patients using a special three-part Medicaid prescription form. It will be very difficult and time consuming for eligible professionals to perform a manual count on the voluminous number of prescriptions they issue on a daily basis.

It is also important to note that for the 2010 Medicare e-prescribing incentive program, no threshold percentage is mandated. Rather, CMS only requires a physician to report the relevant e-prescribing G code on 25 claims during a calendar year. CMS’ rationale for significantly reducing the e-prescribing reporting requirements for 2010 was, “lowering this requirement simplifies the reporting burden, which would encourage eligible professionals to participate in this incentive program, and more importantly, to adopt an electronic prescribing system.” We believe that once physicians begin to e-prescribe, they will continue to e-prescribe when possible so there is no need to require burdensome reporting.

Recommendations:

4.1 - We recommend removing the 75 percent threshold requirement from the measure in Stage 1. We believe eligible professionals should be required attest to having the capability of prescribing electronically and report, where applicable to their specialty and clinical setting, their usage of electronic prescribing.

4.2 - We suggest that if the recommendation outlined in 4.1 is not adopted, the proposed measure for e-prescribing for Stage 1 should be to require eligible professionals to mirror the current Medicare electronic prescribing incentive program and require eligible professionals to attest to e-prescribing permissible prescriptions at least 25 times during the reporting period. However, CMS must make that measure contingent on the applicability of the measure to the eligible professional’s specialty.

4.3 - CMS and ONC should work with the Drug Enforcement Agency (DEA) to expedite the release of the electronic prescribing of controlled substances final rule and ensure that the provisions of that rule do not impose undue burdens on clinicians seeking to integrate electronic prescribing into their workflow.

4.4 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 5: *Maintain active medication list.*

Eligible Professional Measure 5: *At least 80 percent of all unique patients seen by the eligible professional have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data.*

Comment:

Not all providers currently have the technology to do this, especially in some of the specialties where no direct patient contact occurs.

Recommendations:

5.1 - The 80 percent threshold requirement from Stage 1 should be removed. We believe that the eligible professional should be required to attest to having the capability of maintaining an active medication list and report, where applicable to their specialty and clinical setting, their maintenance of such lists.

5.2 - We recommend that a definition be supplied for the term “active medication list” and “structured data.”

5.3 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 6: *Maintain active medication allergy list.*

Eligible Professional Measure 6: *At least 80 percent of all unique patients seen by the Eligible Professional have at least one entry (or an indication of “none” if the patient has no medication allergies) recorded as structured data.*

Comment:

Although we support the maintenance of active medication and medication allergy lists for Stage 1, we do not support the 80 percent threshold requirement. We contend that the manual review and counting of records required to calculate the numerators and denominators is overly burdensome for Stage 1. Given the difficulties of manually calculating numerators and denominators and the lack of automated reporting, we recommend revising these measures for Stage 1 to indicate that eligible professionals only have to attest that the medication and medication allergy lists are up to date. It is important to remember that not all providers currently have the available technology to do this, especially in specialties where no

direct patient contact occurs.

Recommendations:

6.1 - The 80 percent threshold requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the capability of maintaining an active medication allergy list and report, where applicable to their specialty and clinical setting, their maintenance of such lists.

6.2 – We recommend that complete definitions be supplied for the terms “active medication allergy list” and “structured data.”

6.3 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 7: *Record demographics.*

Eligible Professional Measure 7: *At least 80 percent of all unique patients seen by the Eligible Professional have demographics recorded as structured data.*

Comment:

While we generally support the objective for recording demographics, most eligible professional currently record this information in their Practice Management System (PMS). We have concerns that eligible professional may be forced to have their PMS certified as part of their EHR enterprise in order to qualify for the incentive program. Currently there is no certification program for PMS systems, and we do not believe that an appropriate certification process could be deployed in time to meet the Stage 1 timeline. We also have concerns over the impact to reporting “race” and “ethnicity” through meaningful use versus the same data collected via the census. While this data is potentially important in determining underserved populations, it is unclear if the actual determination of demographic categorizations is to be made by the eligible professional or the patient.

Recommendations:

7.1 - We recommend adding “or derive” to the objective, so it would read “record or derive the following demographics.” This change supports the current practice environment where eligible providers extract these data elements from other electronic systems, other providers, or from hospitals that already house this data in order to record specific demographic data.

7.2 - The 80 percent threshold requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the

capability of recording patient demographics and report, where applicable to their specialty and clinical setting, their recording of such data in a structured format.

7.3 – We recommend that a complete definition be supplied for the term “structured data.”

7.4 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 8: *Record and chart changes in vital signs. Record and chart changes in vital signs: height; weight; blood pressure; calculate and display the body mass index (BMI) for patients 2 years and older; and plot and display growth charts for children 2- 20 years, including BMI.*

Eligible Professional Measure 8: *For at least 80 percent of all unique patients age 2 and over seen by the Eligible Professional, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.*

AND

Eligible Professional Objective 9: *Record smoking status for patients 13 years old or older.*

Eligible Professional Measure 9: *At least 80 percent of all unique patients 13 years old or older seen by the Eligible Professional have “smoking status” recorded.*

Comment:

Not all providers currently have the technology to record and chart vital signs and smoking status. This would be virtually impossible for certain providers with little or no direct contact with patients (including some clinicians who utilize telemedicine technology). These proposed objectives and measures on vital signs and smoking status should be added to the clinical quality measure primary care specialty group. We strongly support the use of HIT to improve public health goals, however, for reasons outlined in more detail under the clinical quality measures section, a “one size fits all” approach, which requires the attesting to and/or reporting on metrics that are not clinically relevant to all eligible professionals and their patients, does not help improve quality or practice workflow.

Recommendations:

9.1 – We recommend that CMS remove this objective and measure for vital signs and smoking status from HIT functionality and include them in the clinical quality measures section.

9.2 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 10: *Incorporate clinical lab-test results into EHR as structured data.*

Eligible Professional Measure 10: *At least 50 percent of all clinical lab tests results ordered by the Eligible Professional during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.*

Comment:

In today's healthcare environment, providers rely on third parties to transmit clinical lab data. With the confusion surrounding the boundaries of structured data, we have concerns that this requirement will add a burden of manual data entry into this measure. While this measure does not mandate any exchange of information, the requirement calls for data to be entered into an EHR in a structured format using Logical Observation Identifiers Names and Codes (LOINC). Very few physicians currently order lab services electronically and this is not likely to change substantially in time for Stage 1 of the incentive program.

Laboratory test results are rarely in a form that permits direct integration into an EHR. This forces practices to purchase lab interface software costing thousands of dollars per lab. With no requirement for labs to send physicians this information electronically there are few incentives for labs, especially small ones, to create these necessary interfaces. Thus, incorporating lab test results manually into the EHRs as structured data and calculating nominators and denominators for purposes of meeting the meaningful use requirement will be burdensome and costly for practices, especially smaller practices that lack the resources for these manual interventions.

Recommendations:

10.1 - The 50 percent threshold requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the capability of entering in lab data in a structured format and report, where applicable to their specialty and clinical setting, their entering of such data in a structured format.

10.2 - CMS should clarify that this measure is meant for providers that electronically receive results in the format that is outlined in the Interim Final Rule, and is not an expectation that providers should manually enter the data.

10.3 – CMS/ONC should require compliance with the HL7 2.5.1 standard for lab reporting. This would harmonize the HL7 standard included later in the IFR (submitting lab results to public health agencies).

10.4 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 11: *Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.*

Eligible Professional Measure 11: *Generate at least one report listing patients of the Eligible Professional with a specific condition.*

Comment:

While we support CMS' proposed measure for generating at least one report listing patients with a specific condition during Stage 1, we believe that this report should be required to be generated only once per reporting period. Physicians should have the discretion to generate lists dependent upon clinical relevance to their patient population, and EHR products should include the functionality that enables physicians to do this easily.

Recommendations:

11 .1 - This objective should be modified to read: “Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.”

11.2 - The measure should be modified to read: “Generate at least one report listing patients of the Eligible Professional with a specific condition during the reporting period.”

11.2 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 12: *Report ambulatory quality measures to CMS or the States.*

Eligible Professional Measure 12: *For 2011, an Eligible Professional would provide the aggregate numerator, denominator, and exclusions through attestation. For 2012, an Eligible Professional would electronically submit the measures.*

Comments:

MGMA is committed to quality improvement, including quality reporting. We look forward to the day when automated quality reporting through an EHR provides reliable information that can inform our quality improvement efforts and the public. However, developing and testing measures for automated reporting takes time and it is essential to ensure that vendor products, once installed and in use, produce scientifically valid and reliable data.

The proposed rule includes a broad set of quality measures to be reported by eligible professionals. While we agree that the intent of the rule is to advance quality measure reporting by including measures that can be HIT-enabled as part of the care process, we have concerns regarding the quality measures proposed by CMS. It is critical that data collection and reporting require minimum manual effort and utilize electronic reporting at a summary level. This approach will create an effective foundation for "measures that matter" and validate that these quality measures are appropriate to the clinical venue and/or medical specialty.

The large number of proposed measures will impose a substantial burden on many eligible professionals. In a short period of time, eligible professionals will need to convert from their current manual approach of quality reporting (heavily dependent on chart abstraction) to one where the measures must be based on data captured in the EHR. In addition, the large volume of quality measures already developed for claims-based reporting but not readily available in EHRs, make the current measure sets and timeframes unrealistic to meet the desired goals set forth in the proposed rule.

Successful PQRI participation for most medical practices requires reporting on only three clinical measures, yet the Medicare and Medicaid EHR incentive program requires practices to report at least five measures. If reporting quality measures is required in Stage 1, at the very least MGMA urges CMS and ONC to only require the submission of three measures during Stage 1.

In the 2010 Medicare physician fee schedule, CMS eludes to eventually phasing out claims based reporting options altogether from the PQRI. Comparing the success rates of PQRI participation via qualified clinical registries (96 percent) versus claims-based reporting (49 percent) proves the value and efficiency of reporting quality measures through electronic data collection systems. The increasing dependence on electronic technologies and the rapidly expanding number of various quality improvement and reporting programs demonstrates that there is little room for CMS and ONC to make any implementation errors. For example, there were extensive problems with the ability of practice management systems, electronic claims processing systems, and data clearinghouses to recognize and properly transmit codes associated with the PQRI. Failure by these third-party vendors to

properly recognize the PQRI codes resulted in the failure by many group practices to earn the PQRI incentive payments. This vendor problem illustrates the need to delay, for at least a year, the quality reporting requirements of the Medicare and Medicaid EHR incentive program so that all vested entities have sufficient time to properly prepare.

Additionally, MGMA urges CMS and ONC to specify in the final rule that providers have the flexibility to select which quality measures are clinically relevant for their group practice to report. MGMA also urges that further details regarding the quality measure attestation process used by the incentive program are provided in the final rule. Medical practices are understandably wary of new government programs, therefore prospective participants will only commit to this incentive program once they are fully aware of all quality reporting requirements and deadlines.

Like the PQRI, the EHR incentive program also heavily relies on specific quality data codes. Since there are multiple reporting programs offered simultaneously by the federal government, MGMA urges CMS and ONC to commit to the rapid harmonization of all measures and measure specifications used by the Medicare and Medicaid EHR incentive program with codes used by the PQRI, the electronic prescribing reporting program, and the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

MGMA has serious concerns over the premature use of measures that have not been fully developed, endorsed, and tested. MGMA supports a measurement development process developed through a transparent, multispecialty consensus process such as the AMA-convened Physicians' Consortium for Performance Improvement (PCPI). Given the upcoming transition from ICD-9 to ICD-10 codes and the challenges of attempting participation in multiple reporting programs, the commitment to harmonize all quality measures and measure specifications would greatly reduce the concerns of practice administrators.

CMS and ONC must recognize that the requirement to report quality measures be phased in over a number of years. Sufficient time is needed for the industry to sequence the development of clinical measures for reporting through EHRs (eMeasure), the configuration of software to collect and report these eMeasures, certify the software, have eligible professionals purchase, install and test the software, select the measures, and then collect and report these quality measures.

Recommendations:

12.1 - We recommend the following approach:

Stage 1 / Year 1-Attestation

- **Select at least three clinically appropriate quality measures to report for at least two years, or attest that no clinically relevant measures have been adopted under the meaningful use incentive program for 2011.**
- **If available, download Level I (human readable) measure specifications.**

- Offer participating practices a non-punitive opportunity to test the functionalities of their EHRs to collect and submit the numerators, denominators, and exception codes associated with clinical quality measures.
- Utilize feedback from the testing process to modify specifications, data entry, and missing fields for data entry if applicable.
- Enter measure-specific data elements, if feasible.
- Utilize EHR functionality to support entry of measure-specific data elements (e.g., problem list maintained, lab results entered).

Stage 1 / Year 2-Attestation

- Eligible professionals review measure reports from EHR systems.
- Eligible professionals send summary report to CMS on accuracy and completeness of numerators, denominators, and exceptions for the measures that were selected in the first year of Stage 1.
- Eligible professionals provide feedback to CMS and measure developers regarding accuracy, completeness of eMeasure specifications (e.g., structured data fields are not available).

Stage II

- Eligible professionals export clinical quality data to CMS (or Medicare intermediary), assuming that HHS has the capability to receive data.
- Eligible professionals provide feedback to CMS, EHR vendor, and measure developers regarding data export.

12.2 - We recommend that physicians not be required to report to CMS or the states any clinical quality measure summary information in the initial program year, but rather use Stage 1 to become familiar with the clinical quality measures and specifications, and begin to enter the required data for quality reporting into the EHR system.

12.3 - In implementing meaningful use of certified EHR technology to report on clinical quality measures and other measures specified by the Secretary, flexibility must be exercised in allowing physicians to determine which measures are clinically relevant, adequately specified, tested, and ready for use.

12.4 - Historically, medical practices have had substantial challenges complying with complex federal reporting initiatives. Most practices that attempt the PQRI ultimately fail despite the fact that the program is now in its fourth year. We therefore urge CMS and ONC to heed the lessons learned from implementation of the PQRI.

12.5 - To help ensure the success of the EHR incentive program, MGMA urges CMS and ONC to commit to a long-lasting outreach program that includes national, regional, and local educational opportunities. MGMA remains committed to assisting the government surmount these extensive educational

challenges so that the rapid adoption of EHRs in medical group practices is realized.

Proposal:

Eligible Professional Objective 13: *Send reminders to patients per patient preference for preventive/follow-up care.*

Eligible Professional Measure 13: *Reminder sent to at least 50 percent of all unique patients seen by the Eligible Professional that are 50 and over.*

Comment:

While we support the utilizing of this electronic capability as part of a providers daily work process, we believe that for Stage 1 eligible professionals should have the discretion to issue reminders using a variety of methods. In today's typical practice, there are multiple methods for issuing patient reminders. For Stage 1, the proposed measure should be flexible enough to allow reminders to be provided via phone calls, voice mail messages, emails, printed reminder notice provided after the initial visit, etc. For clinicians who manage sensitive conditions such as mental health, a larger percentage of their patients may request that no reminders (such as phone calls or mailed cards) be sent. Physicians should have the flexibility during Stage 1 to implement method(s) that work best for the physician practice and the patient.

In addition, the proposed denominator would be difficult to capture since many physicians use their PMS system to track appointments and not their EHR. It would also be extremely burdensome for a physician to track how many phone calls were made, letters mailed, emails were sent, etc. Costly interfaces between the PMS and EHR systems would need to be created to allow for the tracking and sending of reminders through the use of EHRs. Furthermore, physicians should have the flexibility to determine if they want to meet this requirement by sending reminders to patients under 50, particularly for those practices serving Medicaid patients.

Recommendations:

13.1 - The 50 percent threshold requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the capability of sending reminders to patients per patient preference for preventive/follow-up care and report, where applicable to their specialty and clinical setting, their sending of such information.

13.2 – CMS should allow the eligible professional to select what patients are to receive reminders, regardless of the age of the patient.

13.3 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 14: *Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules.*

Eligible Professional Measure 14: *Implement five clinical decision support rules relevant to the clinical quality metrics the Eligible Professional is responsible for.*

Comment:

We do not support CMS' proposed measure to require eligible professionals to implement five clinical decision support rules relevant to the clinical quality metrics the eligible professional is responsible for during Stage 1. The financial and staff resources associated with customizing these forms and tools must be taken into consideration before requiring a threshold of five clinical decision support rules to be implemented in 2011.

The measure is unclear as to the specificity of some items (i.e., drug-drug interactions), in terms of their being counted or not counted towards meeting the measure. The measure also includes the term "clinical decision support rules" which may be interpreted differently across the industry. In order to develop appropriate rules, they must be derived from scientific evidence and consensus, much like the measure development process. Once the clinical decision support rules are created, they then need to be incorporated into EHRs, a process that takes time for vendors to implement and physician offices to integrate. We also seek clarification from CMS on whether modifying an EHR clinical decision support tool to meet a practice's needs would in any way negate EHR certification.

Recommendations:

14.1 - The five decision support rule requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the capability of using at least one decision support rule (if there is one applicable to the eligible professionals' specialty) and report, where applicable, their use of such decision support tools.

14.2 - We recommend that more specificity be added to the measure in terms of alert severity, time frames, etc., and that "clinical decision support rules" be clearly defined for the purposes of meaningful use.

14.3 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 15: *Check insurance eligibility electronically from public and private payers.*

Eligible Professional Measure 15: *Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the Eligible Professional.*

AND

Eligible Professional Objective 16: *Submit claims electronically to public and private payers.*

Eligible Professional Measure 16: *At least 80 percent of all claims filed electronically by the Eligible Professional.*

Comment:

These objectives and measures should not be included as criteria for the incentive program. Both of these measures are electronic transactions that are part of the functionality of the practice management/billing system which is separate and distinct from the EHR. In the vast majority of practices it is the administrative staff who conducts these transactions, not the clinical staff. In addition, the vast majority of ambulatory practices utilize a third party (i.e., billing service or clearinghouse) to perform these transactions due to the lack of standardization currently in the industry. Should these transactions remain in the meaningful use definition, and the requirement be that eligible professional conduct these transactions directly with their health plans, we estimate that more than 75 percent of eligible professionals would be excluded from the incentive program. This also creates the potential for a provider's practice management system to come under certification, which adds an additional inappropriate burden to providers.

Most physicians' practice management systems are separate from their EHR systems. To check insurance eligibility per patient, most physician practices go to the payer's website or call the payer to obtain this information. In addition, many physicians have confirmed eligibility on-line with private payers but end up with a denied claim later because the patient had reached maximum benefits on a particular service. As for Medicare patients, there is no widely available electronic eligibility capability, and so physicians have to call Medicare to check on eligibility, which is a time-consuming process. Most clearinghouses used by physicians do not provide real-time eligibility checking, but rather a batch style checking done 24 hours in advance.

Due to the lack of standardized health plan responses, practices are forced to conduct this eligibility verification process manually. The information that is typically returned when a payer does respond is often incomplete. Most payers respond with a simple "yes" or "no" which is of limited value to the physician, because it only tells the physician that the patient is covered; it does not tell the

physician if the patient is covered for a particular service or provide other critical financial information such as co-pays and deductibles .

We also do not believe that CMS should include a requirement for checking eligibility electronically as part of the EHR incentive program criteria when many payers are still not in compliance with the HIPAA 270/271 electronic eligibility standard. We are also concerned that CMS has tied the EHR incentive payments to eligibility during Stage 1 which will coincide with the industry's transition to the next version of HIPAA standards, version 5010. We expect just as with past HIPAA implementations, that there will be implementation barriers physicians will need to overcome, many of which could be outside their control. According to an analysis published in *Health Affairs* ("What Does it Cost Physician Practices to Interact With Health Insurance Plans?" May 14, 2009, web exclusive) co-written by MGMA, an estimated \$31 billion dollars (\$69,274 per practice) is spent annually by physicians interacting with health plans. Much of these costs could be avoided if compliance with HIPAA transactions and code sets was enforced.

As for electronic claims submission, we are unclear on how CMS envisions claims would be sent electronically, and would appreciate clarification on how physicians can submit claims electronically under this requirement. At this point in time, there are many claim submission processes in place, due in part to health plan non-compliance with HIPAA. Some payers require physicians to submit electronic claims through their clearinghouses and are unwilling to provide a direct connection as required under HIPAA. Some payers do not accept electronic claims and therefore clearinghouses are required to drop an electronic claim to paper. Physicians currently submit claims through practice management systems, billing services, or clearinghouses. We are unclear as to whether the proposed objective and measure will allow physicians to continue to submit their claims through the above-mentioned options.

We appreciate the administration's desire for increased administrative simplification and believe that addressing problems associated with accurate, real-time eligibility information and electronic claims submissions separately will result in greater efficiencies for physicians and payers. We would also note that under the Administrative Simplification Compliance Act (ASCA), practices with 10 or fewer full-time equivalent employees (FTEs) are not required by law to bill electronically and this proposed rule does not address this exemption.

We assert that these proposed measures are outside the scope of the EHR incentive programs, and will distract from other incentive objectives and measures that are aimed at improving the quality and efficiency of care and accelerating physician adoption and use of EHRs.

Recommendation:

16.1 – The objectives and measures associated with electronic insurance eligibility verification and electronic claims submission should be removed from the meaningful use requirements.

Proposal:

Eligible Professional Objective 17: *Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request.*

Eligible Professional Measure 17: *At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours.*

Comment:

We believe that the measure providing patients with a copy of the health information upon request is reasonable. However, we have serious concerns with the requirement that those records must be made available within 48 hours and in an electronic format to 80 percent of the patients that request them. Current HIPAA regulations permit providers up to 30 days to compile a patients' medical record and make it available to the patient. There are several reasons why this timeframe is required:

- Records are often stored in multiple systems and potentially multiple locations, even those in an electronic format
- Records are often stored in multiple formats and require time to consolidate into a single format for the patient
- Under HIPAA, providers are permitted to review the medical record and redact any information that they believe could be harmful to either the patient or someone else

By accelerating the timeframe that the provider has to compile and produce the medical record, the proposed rule is placing an undue burden on the physician and the practice's administrative staff.

In addition, the proposed definition of "health information" is overly broad and would potentially include voluminous and possible extraneous information. Further, the objective seems to suggest that the eligible professional is to make available to the patient in an electronic format a single, complete medical record. However, the capabilities of the available clinical summary standards do not facilitate this. Requiring such a broad array of health information would require providing the patient with multiple continuity of care documents (CCD), for example. Similarly, the continuity of care record (CCR) does not convey this level of health information and does not include a discharge summary. In our member research, this measure was identified by the respondents as one of the most difficult to achieve.

Recommendations:

17.1 – HIPAA already permits patients to review and obtain a copy of the medical record. Providing this service to patients is currently part of the

practice workflow. However, due to the lack of appropriate standards and little experience in the industry with compilation and storage, we do not believe the measure requiring eligible professionals to provide an electronic copy of their health information to at least 80 percent of all patients who request them, and provide it within 48 hours, should be included in the Stage 1 criteria.

17.2 – Should this objective and measure be included in Stage 1 of the incentive program, the 80 percent threshold requirement should be removed. We believe that eligible professionals should be required to attest to having the capability of providing patients an electronic copy of a summary their health information and report, where applicable to their specialty and clinical setting, their ability to provide this summary in an electronic format.

17.3 - CMS should modify the measure to allow eligible professionals a minimum of 30 days in which to compile and produce the electronic record to those patients who request it.

17.4 – Any portion of patients’ medical record that has not been converted to electronic format should not be subject to the requirement that it be provided to the patient in an electronic format. Patients continue to remain entitled to request and receive their full medical records under current HIPAA regulations.

17.5 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 18: *Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the Eligible Professional.*

Eligible Professional Measure 18: *At least 10 percent of all unique patients seen by the Eligible Professional are provided timely electronic access to their health information.*

Comment:

We believe that patient access to their health information is a cornerstone of the physician-patient relationship, and empowering health consumers will lead to improved healthcare. At the same time, allowing the patient electronic access to their health information in near real-time is simply not currently feasible for the vast majority of physician practices currently. The NPRM itself appears to support this assertion when it states: *“We recognize that many patients may not have Internet access, may not be able or interested to use a patient portal. Health systems that have actively promoted such technologies have been able to achieve active use by over 30 percent of their patients, but this may not be realistic for many practices in the short term”* (CMS-

0033-P page 93).

Recommendation:

18.1 – We recommend removing this objective and measure from the meaningful use criteria.

Proposal:

Eligible Professional Objective 19: *Provide clinical summaries to patients for each office visit.*

Eligible Professional Measure 19: *Clinical summaries provided to patients for at least 80 percent of all office visits.*

Comment:

Physicians and their administrative staff need sufficient time to complete a clinical summary after a patient visit, collect and review relevant healthcare information, including test results, discuss results with patient, if appropriate, prior to providing a patient with a summary. It may not be practical or necessary for a physician to give every patient a clinical summary of the visit immediately at the end of a visit.

Physicians and patients are in the best position to determine what records are needed and when they are needed. Physicians should also have the discretion to discuss test results with their patients prior to sharing them with patients.

Recommendations:

19.1 - The 80 percent threshold requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the capability of providing patients a clinical summary and report, where applicable to their specialty and clinical setting, their ability to provide these clinical summaries.

19.2 - CMS should modify the measure to include “at the request of the patient” to ensure that only those patients that require and would like this type of clinical summary are provided one.

19.3 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 20: *Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.*

Eligible Professional Measure 20: *Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.*

Comment:

We do not support CMS' proposed objective and measure to have each eligible provider test his/her certified EHR technology's capacity to electronically exchange key clinical information during Stage 1. CMS recognizes in the proposed rule that in most areas of the country, the infrastructure necessary to support such exchange is not yet available. Rather than requiring each eligible professional to test interoperability, we strongly recommend that CMS pursue pilot programs or testing solutions for improving health information exchanges needed for supporting the incentive programs.

Recommendations:

20.1 – We recommend removing this objective and measure from the meaningful use criteria.

Proposal:

Eligible Professional Objective 21: *Perform medication reconciliation at relevant encounters and each transition of care.*

Eligible Professional Measure 21: *Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.*

Comment:

Although we support medication reconciliation, we believe it would be best to defer this objective and measure until Stage 2 or beyond. The Joint Commission is currently revising its National Patient Safety Goal on medication reconciliation. CMS should not attempt to define medication reconciliation processes and requirements separately and differently from The Joint Commission. Doing so will cause confusion and could slow efforts to build and spread best practice models of medication reconciliation. In addition, CMS notes in the proposed rule that the medical community lacks a clear, shared understanding of medication reconciliation and the use of EHR systems to support this process. The 80 percent threshold should remain.

Recommendations:

21.1 –We recommend that CMS defer the medication reconciliation requirement until Stage 2 or beyond.

21.2 – If the measure remains in Stage 1, the 80 percent threshold requirement should be removed. We believe that eligible professionals should be required to attest to having the capability of performing medication reconciliation and report, where applicable to their specialty and clinical setting, their ability to provide medication reconciliation.

21.3 - CMS should clearly define the terms, “relevant encounter” and “transition of care.”

21.4 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 22: *Provide summary care record for each transition of care and referral.*

Eligible Professional Measure 22: *Provide summary of care record for at least 80 percent of transitions of care and referrals.*

Comment:

We support the objective and measure providing a summary care record for each transition of care and referral only upon request but do not support the 80 percent threshold requirement for Stage 1. The denominator for this objective is the number of transitions of care for which the eligible professional was the transferring or referring provider during the EHR reporting period, a requirement that would be burdensome to physician practices. The objective does not specify providing the summary of care record via electronic means. In addition, we have concerns regarding the expected additional burden to providers of manually producing the summary of care record.

Recommendations:

22.1 - The 80 percent threshold requirement from Stage 1 should be removed. We believe that eligible professionals should be required to attest to having the capability of providing a summary of care for transitions of care and referrals and report, where applicable to their specialty and clinical setting, their ability to provide summary of care records.

22.2 - CMS should modify the measure to include “at the request of the patient” to ensure that only those patients that require this type of clinical summary are provided one.

22.3 – We recommend that this measure clarify that the EHR, via certification, be capable of producing the summary care record in multiple formats.

22.4 - We recommend that CMS provide a clear definition for the summary of care for the ambulatory setting.

22.4 - CMS should review the applicability of this measure to all medical specialties with a particular focus on those specialties, provider types, and clinical settings that do not regularly have direct contact with the patient.

Proposal:

Eligible Professional Objective 23: *Capability to submit electronic data to immunization registries and actual submission where required and accepted.*

Eligible Professional Measure 23: *Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.*

AND

Eligible Professional Objective 24: *Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.*

Eligible Professional Measure 24: *Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an Eligible Professional submits such information have the capacity to receive the information electronically).*

Comment:

We do not support CMS' proposed objective and measure to require eligible professionals to perform at least one test of their EHR's capacity to submit electronic data to immunization registries, or to provide electronic syndromic surveillance data to public health agencies during Stage 1. Interfaces with immunization registries and public health agencies do not readily exist and this objective is not relevant to all specialties. We recommend that CMS postpone these objectives and measures until interfaces readily exist for this type of data submission. It is evident that additional time is needed to test these objectives to ensure their readiness.

Recommendation:

24.1 – We recommend removing these objective and measures from the meaningful use criteria.

Proposal:

Eligible Professional Objective 25: *Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.*

Eligible Professional Measure 25: *Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.*

Comment:

Maintaining the privacy of patient health information and the security of electronic health records is one of the foundations of our healthcare system and has been outlined clearly through the legislative and regulatory processes. As such, providers, as covered entities, are required to conduct risk analyses and mitigate any real or potential security vulnerabilities. Requiring an eligible professional to conduct a security risk analysis that is already required under HIPAA is duplicative and adds an unnecessary reporting burden.

Recommendation:

25.1 – We recommend removing this objective and measure from the meaningful use criteria

Conclusion

In conclusion, we strongly support the overall objective of the ARRA incentive program to stimulate adoption of HIT in ambulatory care settings. However, MGMA calls for substantive modification to the proposed rule, and urges CMS and ONC to request an extension of Stage 1 of the incentive program timeframe from Congress to enable eligible professionals to meet the goals of the program.

In order to maximize the success of the program, we also believe that a workable and practical definition of meaningful use must be developed, reasonable and specialty-appropriate measures required, and program logistics created that reduce administrative burden on participating practices. Should the qualifications for participation in these incentive programs be overly stringent or the process too onerous, the government runs the risk of excluding a large percentage of physician practices from participation.

This is a historic opportunity to reform and revitalize the nation's healthcare system. However, considerable work must be accomplished in order to make

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effective HIT widely available. We look forward to working with HHS to facilitate the physician practice transition to EHRs, and make the promise of improving the nation's healthcare system through technology a reality.

Should you have any questions regarding these comments, please contact Robert Tennant, MGMA senior policy advisor, at 202.293.3450 or rtennant@mgma.com.

Sincerely,

A handwritten signature in black ink, appearing to read "William F. Jessee". The signature is fluid and cursive, with a long horizontal stroke at the end.

William F. Jessee, MD, FACMPE
President and Chief Executive Officer