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AMERICAN MEDICAL ASSOCIATION

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
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Washington, DC 20201

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Dear Acting Administrator Slavitt and Acting Assistant Secretary Dr. DeSalvo:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide our comments on and offer a revised version of Stage 3 of the Meaningful Use (MU) program for electronic health records (EHRs). Physicians are incredibly frustrated with the MU program and the impact it has on the design of EHRs. The AMA has raised substantial concerns about the effect of the MU program on the practice of medicine and the innovation of technology. Yet, Stage 3, as currently drafted, continues to restrict innovations in technology for patients and physicians and creates barriers in moving to the new Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs). For example, MU measures currently define patient engagement in a narrow manner without recognizing the vast opportunities of new technologies. Similarly, the MU program's pass-fail structure is at odds with moving towards measuring and assessing care improvement. Since the future of value-based reimbursement depends upon leveraging health information technology (health IT), we believe the MU program must be reassessed.

Our outline for a new Stage 3 is provided in the attached chart as Appendix 1. This new approach to the program moves away from the current structure that focuses on physicians performing specific actions in a fee-for-service environment. Instead, our revised vision of Stage 3 utilizes real-life care scenarios to encourage all participants to exchange data and improve technology. This new framework is not a complete redesign, since we know we must work with already implemented EHR systems. Rather, our intent for a revised Stage 3 is to address the current challenges with EHRs and provide a glide path towards MIPS and APMs. As a required component of MIPS, MU should help coordinate quality reporting and allow physicians and patients to find and use relevant medical information. All objectives should provide room for physicians and patients to explore the best path to achieve these goals.

The following are overarching changes that we believe the Centers for Medicare & Medicaid Services (CMS) should adopt immediately for Stage 3 to improve the program for both physicians and patients.

- **Provide flexibility and eliminate a pass-fail program design;**
- **Allow for multiple methods/paths to achieve desired end goals;**
- **Remove threshold requirements for measures outside of the physician's control;**
- **Re-orient measures away from process-based tasks to highlight goals that are useful to patients and physicians;**

- **Encourage new technology functions to be the focus of certification rather than placing requirements on physicians and patients that may not yet be feasible; and**
- **Support the reuse of data to reduce the burden on documentation.**

In particular, the AMA believes eliminating a pass-fail approach is the only way that the MU program will be able to align and operate within MIPS and APMs. New payment systems will not work if physicians are penalized for missing just one of the numerous requirements or are held accountable for technological failures that are no fault of their own. We anticipate that moving to MIPS and APMs will be challenging, and that delays in the technology and other tools needed for these new systems are likely to occur. Flexibility solves the problem of aligning and melding together different requirements without holding physicians accountable for forces outside of their control. It also allows for sufficient variation to ensure successful participation across specialties as well as future innovation. We see no benefit in having physicians try to adopt the current Stage 3 requirements and then shortly thereafter switch to a new program designed for MIPS and APMs. We therefore urge CMS to adopt flexibility now to prepare for these upcoming changes.

Our revisions to each of the Stage 3 measures and reasoning behind each of our proposals are listed below. In addition, we are providing a link to our comment letter on the proposed Stage 3 rule, which provides even more detail about problems with existing MU requirements and the proposed fixes that should be implemented in a revised version of Stage 3.

Building upon what is working

The MU program has successfully encouraged the adoption of EHRs in both hospitals and physician offices. Most physicians and practices do not want to return to a paper-based system but are committed to making EHRs and other health IT work and improve patient care.

Accordingly, we believe that certain aspects of the program should be maintained to ensure key technology functions and provide stability. **Specifically, we support the current Stage 3 objective and associated measure for protecting patient health information.** We believe that this requirement is not only necessary to protect the privacy and security of patient information but will become increasingly more important as additional health IT tools are launched and utilized by physicians and patients. We therefore recommend that this requirement, as adopted in the Stage 3 final rule with comment period, be retained.

The statute implementing the MU program also outlined a limited set of requirements, including electronic prescribing (eRx). We agree that this is a key aspect of the program and one that is largely meeting the expectations of both physicians and patients. Part of the reason why eRx has achieved successful adoption is that the benefits were clear to both patients and physicians, physician workflow was considered when implementing the process, and governance was clearly established. **We agree that the e-prescribing requirement to transmit prescriptions and conduct formulary checks should be maintained. We do, however, encourage CMS to expand the exclusion category to cover physicians who cannot meet the minimum threshold due to individual circumstance or patient populations.**

Improving workflow

Physicians continue to struggle with the MU program due to interferences in workflow, constant mouse clicks, and data entry that was previously handled by administrative staff. We are very concerned that MU remains the driving factor in the design of health IT. Systems were developed around MU measures and threshold requirements, forcing physicians to act not only as the medical professional but also as the data entry clerk—a misallocation of resources that reduces time with patients. It is no longer appropriate for documentation and proof of measure compliance to

trump physician and patient needs. However, due to the current Stage 3 requirements, it is unreasonable to expect positive changes in the next generation of EHRs unless significant program changes are made.

Based on our member experiences, two of the MU measures that directly contribute to these workflow problems are the requirements for computerized provider order entry (CPOE) and clinical decision support (CDS). These Stage 3 measures focus on counting the number of orders being entered into an EHR, mandate who may enter the orders, and arbitrarily demand that physicians implement five CDS tools without assurance of relevance or usefulness.

CMS has tried to mitigate some of these problems in Stage 3 by clarifying that CDS can encompass tools beyond pop-ups/alerts, other certified staff may enter in orders, and CDS tools can be tied to high priority health conditions rather than only clinical quality measures (CQMs). We believe these changes are headed in the right direction but need greater flexibility to fully remove the ongoing workflow challenges and ensure relevance to all physicians and providers.

We propose the following revised measure for CPOE and CDS:

- **Physician designated staff should be allowed to electronically enter medication, lab, and radiology orders. These orders should be processed electronically without intervention.**
- **Physicians have a choice in selecting at least one CDS tool and the information that is taken into account for CDS. CDS should not only be tied to quality measures and should not be required for the entire EHR reporting period**.

Our revisions focus on what the technology should accomplish, rather than just counting data entry. This change responds to the problem in the current CPOE measure, which does not consider if the order is ever transmitted electronically or actually fulfilled. By focusing only on the data entry, the current Stage 3 CPOE requirement creates workflow challenges when orders require additional steps by staff to actually process the request. Changing the focus of the measure away from data entry and toward actual processing of the order will help ameliorate these concerns and improve productivity. We note, however, that this will require advancements in current technology. Resource location services and patient matching solutions must be prioritized. Many aspects of care coordination will increasingly rely on these components to work seamlessly across health IT vendors. **We therefore urge the Office of the National Coordinator (ONC) to establish a more focused approach of testing the interoperability of health IT.** CMS should also initially remove thresholds to assess if the functionality of processing orders is actually working and include an additional exclusion for circumstances where technology is not yet capable of transmitting and placing an order.

In addition, our revised measure removes the requirement that CDS be limited to clinical quality measures, as CMS has not updated the CQM list in many years and a focus on "high priority health areas" limits how we can use these tools. Expanding the uses of CDS will allow for more innovation and ensure that different specialties can implement tools that are relevant and helpful to their practice and patients, such as meeting quality improvement demands. Instead of requiring a specific number of CDS tools, which can be expensive, the revised measure focuses on the use of CDS where it is relevant and allows physician choice.

Finally, CDS is an area that we hope will grow in the types of interventions that are available to patients and physicians. Precision medicine is one area where, in the future, lab reports and other determinants of health may come together to provide valuable knowledge for patients and physicians. Yet, many physicians often do not have the CDS resources they need to practice effective genomic medicine due to limitations in EHR capabilities. Stage 3 should be built around the interoperability needed to connect and integrate disparate sources of data. CDS tools built on interoperable technology and that add value to patient care will be voluntarily adopted by physicians. Yet, requiring CDS for the full reporting period limits a physician's ability to experiment with and verify the most effective advanced support tools and also creates usability issues as EHRs must document compliance for a full

year. To resolve these problems, our revised CDS measure would not be required for the entire reporting period but would allow time for updates and adjustments.

Expanding patient engagement

The AMA strongly supports patients having unobstructed access to their health information. We believe that any barriers to patients should be removed and are willing to work with CMS, ONC, patients, vendors, and other stakeholders to find innovative and easy-to-use solutions that fully inform patients. Existing MU measures, however, are poorly crafted to promote patient engagement for several reasons.

First, existing measures limit how patients can engage with technology and their physicians. Our members report that patients often want to review their health care data at the point of care, alongside their physician. Instead of incentivizing this behavior, the current Stage 3 measure requires patients to access the data themselves at a later date and time. Physicians are placed in a difficult position of encouraging patients to use portals or applications despite the information being redundant, if already provided at the point of care, or confusing, if provided without the interpretation of a care provider.

Patients have also repeatedly prioritized other functions, such as scheduling appointments, paying for services, refill reminders, and discussing treatment options with their physician over viewing, downloading, and transmitting data. Yet, none of these other activities "count" for purposes of the current Stage 3 measures. The measures also continue to focus solely on the summary of care document rather than the most relevant or appropriate information, creating a one-size-fits-all approach to engaging patients.

Lastly, existing patient engagement measures fail to address the confusion surrounding privacy and security laws. This uncertainty continues to be a major barrier to providing patient access and could be remedied by creating measures that frame how to appropriately share patient information. Accordingly, our revised set of patient engagement measures moves away from focusing on processes and towards promoting a targeted number of important use cases.

As a first step, the AMA believes we should broaden the patient engagement measures to encompass the numerous innovative ways that patients and physicians can communicate and connect with one another. **Instead of having multiple measures that overlap, we urge CMS to adopt a single expanded measure that would include activities beyond viewing, downloading, and transmitting data.** This revised measure could include: reviewing clinical notes (e.g., Open Notes program); accessing lab, prescriptions, or other tests; accessing cost information; and electronic scheduling and paying for visits. The measure would not dictate the type of technology that must be used (i.e., Application Programing Interfaces [APIs] vs. portal) since we believe such criteria stifles new approaches and will become quickly outdated. Providers would still ensure that, when requested by the patient, the full patient record can be made available electronically. The new measure, however, does not place limitations on the interactions between patients and physicians and encourages more specialized care.

We also urge CMS to consider adopting optional measures that focus on specific goals to promote patient engagement. These measures should initially start with ensuring functionality only and not mandate a certain percentage of patients perform tasks, allowing for maximum flexibility and innovation. Framing measures to address specific goals or outcomes will also help resolve some of the barriers related to interoperability, as outcomes will require improved data collection and exchange. Suggested goals for broadening patient engagement could include the following; however, we are open to discussion with other stakeholders, patients, CMS and ONC to ensure all interests are being met.

- **Tracking patient consent –** Patient consent can be recorded and tracked across care settings.

- **Coordinated data collection –** Physicians and patients should work together to identify what information needs to be collected in order to help diagnoses or treat a condition. Data should be tagged to identify where, when, and how it was collected.

In addition, we disagree with the requirement for all physicians to accept patient generated data (PGD) when there is no existing standard for the technology to support this function. **We urge CMS to recognize that the appropriate use of PGD is still being explored and rushing into a new measure requirement may negatively affect the adoption of PGD tools.** PGD has the potential to help identify problematic trends like rapid weight gain or fluctuations in blood pressure and become a key component in providing patient-centric care. Yet, methods for tagging and analyzing these data are still in development. By mandating PGD at this time, we worry that physicians and patients will be required to purchase and implement poorly-functioning technology and handle voluminous, unstructured data. **Instead, CMS must allow patients and physicians time to first explore how best to manage this new flow of information before MU requirements are set in stone.** The 2015 Edition certification for PGD capture is an appropriate first step and experimenting with uses of PGD will help identify which health IT capabilities are needed before adopting measures that are overly prescriptive or infeasible.

Achieving interoperability

The lack of interoperability continues to be a challenge for achieving the benefits of EHRs; yet, the Stage 3 measures focusing on data exchange adopt the same failed approach found in Stage 2 of the program. These measures are too focused on the quantity of information moved and not the relevance of these exchanges or the underlying business case for transmitting data. Furthermore, the measures take an overly broad approach trying to achieve interoperability as a concept rather than solving more concrete data exchange and technology problems.

To remedy these concerns, the AMA believes measures should be refocused to address specific instances of data exchange, such as those outlined below:

- **Closing the Referral Loop –** Identify the reason for a referral, integrate provider lists, ensure findings are sent back to the referring physician. Relevant information should be filtered and highlighted automatically by health IT based on patient/physician protocols.
- **Team-based Care** – Patients, care givers, and care teams have access to care plans and are able to update the plan through a variety of methods. Health IT should have the ability to analyze data to inform changes in the care plan.
- **Notification of Tests/Admissions –** Identify and alert the provider with accountability when admitted to another care setting or test results are available.

Building goal-oriented measures reduces the complexity of interoperability by breaking down data sharing activities into manageable aspects. This allows the technical, financial, and governance problems to be addressed so that interoperability is achievable. Equally important, each scenario can include a distinct implementation guide removing all ambiguity about how to implement the data exchange standards. These measures should first focus on functionality to ensure that the data exchange is technically feasible and that specific actions required to perform these tasks can be incorporated into physician workflows. Our suggestions also follow the work by the Advanced Health Models and Meaningful Use Workgroup that is trying to address how health IT will enhance APMs and allow for measuring outcomes and other care models. We agree that this work is heading in the right direction and should be leveraged for Stage 3.

Our previous MU comments have also expressed the need for CMS and ONC to prioritize the infrastructure needed to promote interoperability: patient matching strategies; a national provider directory; clear guidelines for privacy and security; and standards that ensure information has the same meaning and is consistently shared in the same format. The AMA and other stakeholders are working to establish this infrastructure; however, progress is limited

by federal requirements and tight timelines. While Stage 3 touches on some of these issues, the objectives are not unified around interoperability nor is there sufficient attention on ensuring these fundamentals are in place. **We urge CMS to focus MU measures on these key interoperability priorities. CMS must consider the available time and resources of both physicians and health IT vendors before adding additional requirements that do not directly relate to interoperability.**

Greater exchange of patient data does not mean that we are achieving interoperability and better coordinated care. Data exchange must be relevant, useful, and actionable, which requires more than counting how many times voluminous documents are sent back and forth. To improve interoperability, CMS and ONC must work with the physician community to improve the underlying data captured within the EHR and other health IT, including registries. This activity must occur through a physician-led consensus process that includes all specialties and practitioners since it is the physician community who understands the clinical context of the data elements. The following are key steps that must be taken to achieve true interoperability:

- **Uniform clinical data definitions -** A uniform understanding of clinical terms across caregivers will ensure consistent meaning when the data is captured, interpreted, exchanged, and re-used. This one set of standard textual definitions must be vetted throughout the clinical community to ensure its relevance. Some registry organizations, large health systems, and third party vendors are beginning this work; however, these efforts must be coordinated to ensure that one national set of standard definitions is used. Accordingly, we believe that a national, multi-stakeholder physician-led organization that is a leader in quality improvement, outcomes, and performance measurement should lead this effort.
- **A national set of standard terms and mappings -** Beyond data definitions, data exchange also requires the development, maintenance, and refinement of administrative code sets such as the International Classification of Diseases (ICD) and Current Procedural Terminology (CPT®) and clinical vocabulary standards such as SNOMED Clinical Terms® (SNOMED CT®), Logical Observation Names and Codes® (LOINC) and RxNorm. Creating standards and mapping tools will facilitate working across these different codes and ensure consistency when data is exchanged.
- **Standard formats -** Certain data, such as numerical data elements, should have standard formats. For example, patient age or date of birth can be entered and stored as 012915 or January 29, 2015. This level of variability makes it difficult to query and exchange data across multiple and disparate systems. We recommend using standards, such as LOINC, to create uniform data formats so that all systems can exchange and interpret data consistently and accurately.

The AMA along with the house of medicine is ready to assist with these tasks, but can only do so with adequate funding to coordinate these efforts.

<u>Improving public health/Clinical data registry reporting</u>

While the AMA strongly supports connecting to clinical registries and public health authorities (PHA), the current objective is causing confusion in the industry and forcing physicians to scramble to meet an expensive new requirement that takes effect late in the 2015 reporting period. There is now a burden on physicians to register and engage in PHA reporting when there is no guarantee that the state and local PHA is capable or can meet the standards in time. CMS does not have the authority to require public health entities to standardize the way they receive data. We understand that the state-run public health agencies have been unable to keep up with the connectivity demand generated by the MU program. Most states have limited resources and will not be prepared financially or technologically to respond to the numerous connection requests that will now be required. We are also concerned that many vendors will charge to connect with each physician's desired PHA or registry, charging thousands of dollars or outright refusing to connect to certain registries. Ultimately, this may limit options, especially for certain specialties.

We are also concerned because the 2015 certified EHR technology (CEHRT) rule does not include certification standards for connecting EHRs with a registry. EHR code extraction is not available for the vast majority of clinical data registries. The CEHRT rule only addresses standards with EHRs and PHA. Essentially, vendors do not have to be accountable to meet the registry measure option. **We believe CMS needs to play a greater role in facilitating the use of clinical data registries by encouraging the development of standards for sharing and transmitting data between EHRs and registries.** Presently, many practices are forced to manually enter data into a registry either because no streamlined process exists or due to the proprietary nature of health IT products. The manual data entry requires a full-time or half-time employee, which is an added cost that most practices cannot easily absorb. In addition, EHR vendors charge physicians and registries a cost to map and transmit data from an EHR to a registry. **Accordingly, we believe the registry measure exclusion should be expanded to include when vendors may not connect or make it cost prohibitive to connect to a physician's preferred registry.**

Registration Timeframe

We appreciate the exclusion provided from the measure in 2015 but believe that physicians will still not be able to the meet the requirement in future years. A significant challenge is that registration must be completed within 60 days after the start of the EHR reporting period. Yet, we are currently hearing that vendors/third parties lack the ability to handle the onslaught of requests within CMS' timeframe. Connecting to a PHA or registry requires a physician practice to enter into a legally binding contractual agreement and assure the connectivity is secure, which may take more than 60 days. There are also various factors a physician may have to consider outside of routine practice before connecting, such as complying with human research subject protections, researching the availability of a PHA and registry in their jurisdiction and specialty, vendor willingness to connect to their desired third parties, the cost charged by the EHR vendor to connect, and the cost to participate in one of these PHA and registry activities.

Given these concerns, the AMA recommends CMS:

- **Alter the definition of "Active Engagement" in Option 1 to "contact was initiated by the physician to the PHA or registry via email or written notice within the EHR reporting period;**
- **Expand the exclusions to account for specialty variation. A more appropriate exclusion is "does not treat or diagnose or directly treat any disease or condition associated with Measure 1, 2, 3, or 5;"**
- **Allow a physician to receive credit when submitting to PHA in the method expected by their state or local agency;**
- **Deem a physician who is participating in a registry/Qualified Clinical Data Registry (QCDR) activity (see quality section for more details) as satisfying MU quality requirements. Actively engaging with a QCDR is a form of quality improvement that should be sufficient to satisfy quality reporting without duplicating efforts; and**
- **Expand the registry measure to include the fact that a vendor may not connect or make it cost prohibitive to connect to a physician's preferred registry.**

Overall, given the above concerns, the AMA urges CMS to make the Public Health/Clinical Data Registry Reporting objective optional at this time.

<u>Enhancing Quality</u>

We appreciate CMS' effort to align MU clinical quality requirements with PQRS/MIPS by addressing future quality reporting requirements in the Medicare Physician Fee Schedule. We are, however, concerned that vendors will struggle with the growing complexity of quality measures. We remind CMS that one of the main statutory intents of the MU law was quality reporting, but the current program has treated quality reporting and measurement as an afterthought. This is evidenced by the fact that CMS has been unable to update the MU quality measure list since 2011.

To improve quality reporting, MU must support the reuse of data to reduce the burden of documentation. Data that is necessary to support quality measurement, MIPS, APMs and MU should facilitate a "collect once, reuse many times" structure. The AMA, through CPT, is participating in activities to support ontological structures that will provide pathways for better data collection and analytics. We urge CMS to incorporate this work into its implementation guides and make the following program improvements:

- **Work with physician-led community to align clinical data standards;**
- **Help coordinate and test data capture and reporting standards between EHR vendors;**
- **Improve infrastructure to accept electronic transmission of measures (the only way for CMS to currently accept this information is through electronic generation of files);**
- **Prioritize the capture of demographic data to reflect the need for clinical diagnosis;**
- **Eliminate the certification requirement on registries that report CQMs; and**
- **Wherever possible, reuse data to reduce the documentation burden on physicians and staff**.

eCQM and Certification Criteria

We appreciate CMS' attempt to lessen the reporting burden on physicians by allowing technology to be certified to the Quality Reporting Document Architecture (QRDA) Category I and III standards and the optional CMS "form and manner" guidance. While this is intended for future health IT seeking the 2015 Edition of CEHRT, we are concerned with the continued variances in implementation guides (IGs) between QRDA I & III, consolidated clinical document architecture (C-CDA), and CMS' form and manner requirements.

EHR vendors who wish to support both QRDA and C-CDA standards must accommodate differences in the way patient data is managed when applied to the QRDA for CMS quality reporting and the C-CDA standard for data exchange. To support both functions, vendors often rely on CMS' IG to explain methods and workarounds to bifurcate data for both purposes. Yet, this bifurcation may not always be correctly reconciled. EHRs may report quality data in the format that CMS stipulates and in a separate format for data exchange. The difference between C-CDA conformance and CMS' QRDA IG means data adjusted to comply with CMS' version of the QRDA report is less likely to be properly structured in the C-CDA and may not be present in routine transfers of clinical care.

As an example, the clinical reasons for an exception in a patient's treatment should be available to other providers who are also caring for that patient. However, this information may not come across if the original data is manipulated for QRDA formatting. **The EHR data may be reported to CMS correctly, but C-CDA conformant summaries of care sent to other physicians may not include the exception reasoning**. Thus, other physicians may not be aware of the exception and might mistakenly treat the patient without knowing why the referring physician avoided that treatment in the first place.

Part of the issue can be attributed to the variability between the timing of Health Level Seven (HL7) balloting for QRDA I & III, C-CDA, and CMS' form and manner guidance updates. We understand that the process of update publication, balloting, and comment resolution is necessary for the right consensus among standards development organization members. However, there are already well-documented problems with variability between vendors implementing C-CDA IG (e.g., summaries of care) and the resulting lack of functional interoperability we see today. There is also significant concern with the effort to support CMS' form and manner requirements in addition to HL7's QRDA IG and the resulting data discrepancies that may lead to patient safety issues.

Requiring C-CDA, QRDA, and CMS' form and manner conformance is excessive for vendors and variations in IGs means that information has to be modeled differently for reporting and direct patient care. While CMS' intent may be to simplify reporting, the proposed approach could lead to patient safety issues. **We therefore recommend that CMS and HL7 should align standards before further programmatic requirements are finalized. We**

recommend that CMS embrace the spirit of interoperability and only establish requirements that both QRDA and C-CDAs can handle without complex IGs or workarounds. We further recommend that ONC's health IT certification process expressly test for tight conformance to any standard required by CMS.

Electronic Reporting of Clinical Quality Measures

The AMA is concerned with CMS' proposal to require CQM electronic reporting by 2018 due to the lack of investment in health IT infrastructure. We urge CMS to not move forward until the above mentioned challenges are addressed, which are necessary for successful MIPS and APM programs. We already know that CMS and the EHR vendors are struggling to capture and report process measures that have been in place for several years. To resolve some of the challenges, CMS needs to put in place an administrative process to ensure that vendors update their systems to incorporate new data elements as well as to ensure eCQMs can be exchanged, captured, and transmitted within the EHR.

Fixing and updating CMS' internal infrastructure would also allow for an easier eCQM submission process for vendors and physicians. Currently, eCQMs are generated in the EHR based off of content documented in the patient chart, but the actual submission process requires a manual upload by the vendor to a CMS website. For patient level reporting, this can be hundreds of thousands of files per physician. Allowing the submission of quality measures to occur electronically could permit ongoing submissions throughout the reporting period and move us closer to real time reporting and feedback for physicians. Yet, without significant upgrades, it remains premature for CMS to move away from attestation at this time.

QCDR reporting and MU

Currently, if a physician would like to receive credit for participation within a QCDR for MU quality, their QCDR must be certified and the measures must be part of the eCQM measure list. Yet, as we have pointed out in previous comments, CMS has not updated the eCQM list for years and has no intention to update the eCQM list until 2017. The more meaningful outcomes-oriented measures are often reported through a QCDR and are not always captured in an EHR due to the lack of functionality and interoperability. Therefore, the AMA recommends the following to streamline and improve quality reporting:

- **Deem a physician who is participating in a QCDR as satisfying MU quality requirements;**
- **Physicians who successfully participate in MIPS quality, regardless of reporting mechanism, should be deemed as successfully meeting the MU quality requirements; and**
- **Scale down the number of quality measures required to report until there are enough eCQMs that work for all physician specialties**.

Timing

The AMA understands that some of our proposed revisions may require upgrades or certification changes. We fully recognize that vendors should have adequate time to ensure products are usable and capable of performing new functions and that deadlines should consider the product development timeline. In particular, the move to use cases for the patient engagement and health information exchange measures may take additional time and resources to fully develop the necessary technology and functionality.

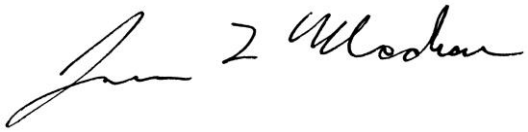
To accommodate these changes, the AMA believes that the new measures should first focus on simply achieving functionality rather than requiring a certain percentage of patients or actions are taken. Furthermore, CMS should break down measures to address specific elements that are necessary for the technology to function. For example, the use case for closing the referral loop may initially include a measure for the participant to publish his/her interoperability contact information, ensuring that all parties can contact one another.

Our revisions also include changes that we believe can be more readily tackled without requiring significant technology alternations. These include removing the link between CDS and quality measures, expanding and simplifying the view, download, transmit measure to incorporate additional interactions, revisions to the public health reporting measures and changes to the quality reporting requirements. We urge CMS to prioritize these more short term modifications now to help both vendors and physicians move to Stage 3.

Conclusion

The AMA appreciates the opportunity to comment on Stage 3 of the MU program and is eager to help advance our nation towards an interoperable, safe, and secure learning health system. We stand ready to discuss our ideas and work collaboratively to achieve these goals. If we can be of any further assistance, please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD

Attachment

Appendix 1: Revised Stage 3 Chart

Objectives	**Current Stage 3**	**Revised Stage 3**
Protect Patient Health Information	Conduct or review a security risk analysis	No change – Conduct or review a security risk analysis
Electronic Prescribing	60% Transmit & Formulary Check	No change – 60% Transmit & Formulary Check
Clinical Decision Support (CDS)/ Computerized Provider Order Entry (CPOE)	5 CDS Implementations Drug-Drug/Allergy check enabled 60% Medications Orders 60% Lab Orders 60% Imaging Orders	Physician designated staff allowed to electronically enter in medication, lab, and radiology orders when these orders can be processed electronically and without intervention. Physicians have a choice in selecting at least one CDS tool and the information that is taken into account for CDS. CDS should not only be tied to quality measures and should not be required for the entire EHR reporting period.
Coordination of Care Through Patient Engagement	80% Timely Access (48 hours) via VDT and API 35% Patient educational resources (all electronic) 10% Use VDT and/or API 25% Have Secure Message Sent by Patient/ Representative or Physician 5% Patient Generated Data is incorporated	Existing patient engagement measures fail to address the confusion about HIPAA and privacy laws. This can be remedied by creating measures that frame how to appropriately share patient information. Measures should initially start with ensuring functionality only and not mandate a certain percentage of patients or what technology can be used (e.g., APIs vs. portal). • **Tracking Patient Consent –** Patient consent can be recorded and tracked across care settings. • **Patient access to care information –** Broaden options for patient engagement to include: reviewing clinical notes (e.g., Open Notes program); accessing lab, prescriptions, or other tests; accessing cost information; and electronic scheduling and paying for visits. Providers should still ensure that, when requested by the patient, the full patient record can be made available electronically. • **Coordinated data collection –** Physicians and patients should work together to identify what information needs to be collected in order to help diagnoses or treat a condition. Data should be tagged to identify where, when, and how it was collected.
Health Information Exchange	50% Summary of Care Created/Sent 40% Summary of Care Integrated into EHR 80% Clinical Data Reconciliation	Health information exchange is too focused on the quantity of information moved and not the relevance of these exchanges. Measures should be changed to highlight the business case for exchanging data and should start with ensuring functionality. • **Closing the Referral Loop –** identify the reason for a referral, integrate provider lists, ensure findings are sent back to the referring physician. Relevant information should be filtered and highlighted automatically by health IT based on patient/physician protocols. • **Team-based Care** – Patients, care givers, and care teams have access to care plans and are able to update the plan through a variety of methods. Health IT should

Objectives	**Current Stage 3**	**Revised Stage 3**
		have the ability to analyze data to inform changes in the care plan. • **Notification of Tests/Admissions –** Identify and alert the provider with accountability when admitted to another care setting or test results are available.
Public Health Reporting / Clinical Data Registry Reporting	Active Engagement (2 of 5): 1. Immunization Registry 2. Syndromic Surveillance 3. Case Reporting 4. Public Health Registry 5. Clinical Data Registry	**For all measures**: Alter the definition of "Active Engagement" to "contact was initiated by the physician to the clinical data registry (CDR) or public health authority (PHA) via email or written notice within the EHR reporting period." Make the PHA and CDR measures optional at this time. **Immunization Registry Measure**: Allow data to be submitted in the method expected by the state or local agency, but not the certification standard. **Clinical Data Registry (CDR) Measure**: Expand the CDR measure exclusion to include that a vendor may not connect or may make it cost prohibitive to connect to a physician's preferred CDR.
Quality	Requires electronic submission for quality measures.	PQRS/MIPS quality should automatically satisfy MU quality requirements—specifically permit QCDR reporting to count towards satisfying MU quality requirements, but do not require QCDR measures to be within the MU program. Continue to allow attestation of clinical quality measures (CQMs), as opposed to requiring electronic reporting by 2018.