



Physicians Caring for Texans

May 7, 2012

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

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2;  
CMS–0044–P; RIN 0938–AQ84

Dear Acting Administrator Tavenner,

The Texas Medical Association (“TMA”) is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, our maxim continues in the same direction: “Physicians Caring for Texans.” TMA’s diverse physician members practice in all fields of medical specialization.

On behalf of our more than 45,000 member physicians, the Texas Medical Association (TMA) appreciates this opportunity to review and offer comments on the above referenced proposed rules relating to Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2. The following comment is offered.

### **Overarching Comments**

Regarding Stage 2, TMA believes that CMS should:

- carefully align meaningful use goals with market ability. Hastily developed systems lead to patient safety issues. Much of Meaningful Use value comes through health information exchange (HIE). Texas has received \$28 million through HITECH incentives to develop HIE infrastructure, yet most funded HIEs have yet to implement the ability to query and effectively exchange patient information. CMS and ONC should analyze market capabilities to ensure the market place is ready for all proposed criteria prior to moving requirements to “Core”.

- provide adequate exclusions so that specialists and focused generalists (e.g., pediatricians and OBs) are able to fully participate in the program.
- provide a way for physicians who are forced to switch EHRs (e.g., because of a vendor decision to discontinue a product) to have a way to participate in Medicare Meaningful Use without losing a year of incentives during the transition. This is especially true if a physician is required to drop to paper during the transition. With over 1,200 certified EHRs this will be a likely issue as the criteria becomes more difficult for smaller EHR companies forcing them to either close or be sold to a larger company. For example, this is happening to physicians who use an Allscripts product that is being sunsetted after Phase 1. TMA recommends that physicians in this situation should be permitted to meet only 90-days of Meaningful Use during a transitional year, with appropriate documentation of making the transition to a new certified EMR.

CMS and ONC should consider that when physicians are forced to transition to another EHR, the data migration is very expensive and can be cost prohibitive for small practices. For example, a physician in Texas was recently forced to change EHRs because a major vendor was sunsetting the product this physician had purchased only 9 months before. The new product that the vendor recommended cost twice as much as the product initially purchased. Because of the price difference, the physician shopped around and decided to switch to another company. The cost for the physician to migrate only 9 months of patient data was \$12,000. One possible solution to this problem would be to require vendors to tag key data element that would typically be moved in an EMR transition with standardized XML. Vendors would also need to be able to receive and process data feeds with this standardized XML, and store it in its native tables. This process is used for the CCD/CCR but on a limited scale. This process would also assist with transfers of Meaningful Use data to HIEs that are not part of the current CCD/CCR, such as smoking cessation.

### **Specific Comments**

*Page 13704*

**Comment:** TMA agrees with the proposed changes to the Stage 1 objectives as detailed in the proposed rule. The Stage 1 objectives that impose increased burden and require more robust EHR functionality would appropriately be delayed until 2014.

**Comment:** TMA believes that the objective of “capability to exchange key clinical information” should be moved from Stage 1 to Stage 2.

**Rationale:** The other three options increase the burden on physicians and could impede their ability to adopt an EHR which is the primary goal of Meaningful Use in Stage 1. The increased burden required to exchange clinical information aligns with the goals of Meaningful Use in Stage 2 and should therefore not be required until that stage. TMA suggests changing Stage 1 to include a successful test of the exchange of clinical information starting in 2015. By then this functionality should be ubiquitous among EHRs in preparation to meet the quality outcome objectives in Stage 3.

**Comment:** TMA agrees that submission of syndromic surveillance data to public health agencies should remain a menu set for EPs. Most public health agencies do not yet have the capability to receive encrypted discrete data.

*Pages 13708 - 13711*

*Proposed Objective:* Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines to create the first record of the order.

*Proposed Measure:* More than 60 percent of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

To calculate the percentage, CMS and ONC have worked together to define the following for this objective:

- Denominator: Number of medication, radiology, and laboratory orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.
- Numerator: The number of orders in the denominator recorded using CPOE.
- Threshold: The resulting percentage must be more than 60 percent in order for an EP, eligible hospital or CAH to meet this measure.

*Exclusion:* Any EP who writes fewer than 100 medication, laboratory and radiology orders during the EHR reporting period.

To qualify for the exclusion, an EP's total number of medication, laboratory and radiology orders collectively must be less than 100. For example, an EP who writes 75 medication orders, 50 laboratory orders and no radiology orders during the EHR reporting period would not meet the exclusion.

**Comment:** The NPRM does not make it clear whether paper orders need to be counted as part of the CPOE measure's denominator. Also, it is not clear whether an electronic communication order should be counted, such as one to a nurse: "Give ceftriaxone 250mg IM in clinic now." This should be clarified. If these are intended to be counted, CMS should consider the considerable manual work that would be required to capture this information as well as problems with adjusting EMR-calculated totals, which may not be possible.

**Comment:** This CPOE objective is aligned with the important challenges of CPOE in the hospital setting but not with the important challenges in the EP office setting.

**Rationale:** There are several significant work flow and cost differences between CPOE usage in a hospital and CPOE usage by an EP in their office. Physician work flow in an office using an ambulatory EHR is actually impeded when orders are handwritten. On the

contrary, in hospitals, physicians often see their work flow improved when they handwrite orders. The resulting increased costs are absorbed by the hospital. These are reasons why the struggles that hospitals have encountered with CPOE over the past decade are not being encountered with ambulatory EHR implementations.

- a. In a hospital setting, the “Order Entry” system is typically set up to allow unit secretaries to transcribe a physician’s written orders in addition to allowing physicians to directly enter electronic orders themselves. Transcribing a physician’s written or verbal orders is sometimes appropriate such as when the physician is “hands-on-the-patient” during a code. Ambulatory physicians streamline their own work flow by writing orders because it is faster to do so and they do not have to employ the resources to do the additional work their written order creates. Also, when EPs attempt to review a patient’s orders in the EHR it is much more cumbersome to toggle between orders found in the electronic orders section and the orders that were scanned into another section of the EHR. Written orders create a cumbersome process that is costly to the physician. These are strong disincentives that result in much less resistance to using CPOE in the office setting as compared to the hospital setting. The proposed CPOE metric is therefore quite useful for hospitals to move CPOE forward, but is not needed on the ambulatory side.

Also, hospitals have IT expertise that physician offices do not have to create reports that establish a denominator of all orders (orders entered into hospital’s “Order Entry” system whether written or directly entered by clinicians) and a numerator of orders entered directly through CPOE (i.e. by licensed clinician).

It should be pointed out that if EPs are expected to count written orders in the denominator, this will be a very cumbersome manual effort which hospitals do not have to do because they employ resources upfront to transcribe written orders into the inpatient EHR as discrete data, and they have the IT expertise to write reports that automatically extract that information. EPs typically do not have the written orders transcribed and captured as discrete data, nor do they have the IT expertise to write reports.

In summary, writing orders in hospitals can be more convenient for physicians and they do not feel the impact of the additional work it creates. But with an ambulatory EHR the use of written orders is cumbersome and costly to physicians. EPs do not need a meaningful use objective to motivate their use of ambulatory CPOE. Objectives that require the use of at least some electronic ordering (as suggested below) will naturally lead to full adoption of CPOE in ambulatory settings due to the work flow efficiencies and cost savings.

- b. The same is true for other types of orders. EPs commonly send patients to another facility to have the lab or radiology tests done. These orders could be entered into the EHR as a nurse communication order, as free text in a progress note or even written and then later scanned into the EHR. Also, the lab or radiology results could be faxed to the practice and scanned into the chart. Hospitals do not commonly send patients to other facilities for tests, so this is not a problem which they frequently encounter. However, the use of written lab and radiology orders like this creates a very cumbersome work flow for the EP’s office and increases costs, just as with

medication ordering. There is a natural incentive to use CPOE in the office unlike in a hospital.

- c. The bulk of medication orders by most EPs are outpatient prescriptions that will be entered through the e-Rx system even if they are printed instead of transmitted electronically. Some medications, though, are administered in the office. For some physicians this is rare, but for others it is common. For these medication orders EPs will, in general, order the medication through the eRx system and/or enter a communication order to the nurse to give the medication. In some situations the medication may be ordered as a part of a nursing protocol, such as “Give Tylenol 325mg for fever>39”. These orders are managed differently depending on the EHR product and on how it is configured by the practice. If the eRx system is not used, the nurse will then have to enter the medication into the medication list as part of the medication administration documentation process. If the eRx system is used, it will generally be entered as a “Nurse administration” type order that will trigger some sort of notification process such as an electronic message to a nurse, a task on a “To Do” list or a printed message, but the medication will automatically be added to the list.

The proposed metric does not address the challenge of medications administered to patients in the office. For the same reasons as in (a) above, written orders will be perceived by EPs as too cumbersome to use. Instead of focusing on encouraging EPs to enter orders electronically the metric should focus on ensuring that e-prescribing and electronic medication reconciliation is occurring. A majority of medications ordered in the office are associated with a medication on the medication list. This will discourage the use of communication orders (which bypasses CDS) to order meds that are administered in the office and discourage those who might initially try writing orders after implementing an EHR. The e-prescribing metric would still be appropriate to encourage use of electronic transmission of those orders.

**Comment:** The CPOE metric used for EPs in the ambulatory setting should not focus on encouraging EPs to use electronic ordering. Instead, the focus of medication ordering should be to have the majority of medication prescriptions entered into eRx electronically transmitted to a pharmacy and electronic medication reconciliation performed. The focus for lab and radiology orders should be to have the majority of electronic lab and radiology orders be associated with a result that is electronically captured in the EHR as a discrete data element. TMA, therefore, suggests two separate CPOE objectives for EPs.

1. For medication ordering: use the eRx measure and medication reconciliation measures that are already proposed.

eRx objective: More than 65 percent of all permissible prescriptions written and entered by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology

Exclusions: Any EP who writes fewer than 100 prescriptions during the EHR reporting period or does not have a pharmacy within their organization and has no pharmacies that accept electronic prescriptions within 25 miles of the EP’s practice location at the start of the EP’s EHR reporting period.

Additional exclusion: Medications dispensed in clinic.

2. For lab and radiology orders:

Denominator = Number lab results + radiology interpretations received by EHR for patients seen by EP during reporting period.

Numerator = Number of lab and radiology orders ordered electronically by clinician.

This measure must account for tests that are ordered in a group or panel. Each order should be linked to results in a 1:1 manner. For example, a panel order, “Lytes II”, produces 5 results in the EHR. The EHR should be configurable such that one attribute of the Lytes II order is that it is linked to 5 results. This built-in attribute will enable a report to create a 1:1 ratio of “#orders : #results” even if panel orders are entered. The 2014 EHR certification criteria may need to add a requirement for this lab attribute field to be available in their product.

*Pages 13710 - 13711*

**Comment:** TMA suggests that the use of e-prescribing for controlled substances be added as a menu set option.

**Rationale:** In addition to the DEA rules, each state has different laws and regulations that must be changed in order to accommodate e-prescribing for controlled substances. In anticipation of the ability to e-prescribe controlled substances, Texas law has been modified as needed. However, TMA does not anticipate that physicians will embrace e-prescribing for controlled substances until the technical and procedural aspects are established in Texas and usage has been successfully achieved by early-adopters or piloted by physicians. While TMA remains hopeful that e-prescribing of controlled substances will be ready for wide spread adoption by 2014, we cannot advocate for this to be required until it has been successfully piloted in Texas.

**Comment:** TMA believes there should be an exclusion which states that prescriptions provided by EPs in a facility that does not use the EP’s certified ambulatory EHR are excluded from the denominator.

*Pages 13711 - 13712*

**Comment:** TMA strongly opposes the inclusion of disability and sexual orientation data.

**Rationale:** The data set for what determines a disability is not well enough defined for EHR reporting. There are many social and clinical situations that can be considered a disability, but no patient care purpose is served by collecting such data. It would be extremely intrusive, especially in certain specialties, for physicians to ask their patients about their sexual orientation. Even if these discussions did take place, it is highly unlikely that patients would feel comfortable having this recorded in their EHR and, therefore, it may discourage patient participation in HIEs.

**Comment:** TMA strongly believes that the ability to plot and electronically display growth charts for patients should be required for all certified EHRs. ONC EHR Certification should not

establish optional criteria unless ONC is willing to add “qualifications” to certification such as “Child Profile” or other specialty or patient segment profile (which has not been discussed as an intent).

**Rationale:** EHR certification has not been developed with intent to be specific to physician specialty or specific to certain patient populations. Therefore, if a pediatrician purchases a 2014 Edition Certified EHR, the product should be expected to meet all EHR Incentive Program objectives including the ability to plot and display growth charts. Use of growth charts is not a small, niche aspect of healthcare; pediatric-aged patients cumulatively comprise one-third of ambulatory patient visits each year. It is not reasonable to create optional criteria for functionality that is required for such a large segment of the population. Also, establishing optional criteria implies that ONC certification is specific for targeted specialties or targeted patient populations. Since ONC is not qualifying certification as “Child-Friendly” or other “specialty”-friendly, the optional criteria creates an unintended potential to confuse or even mislead physicians. This particular optional criterion also provides EHR vendors the unintended leeway to not provide functional criteria that is necessary for a large segment of patients, and yet they may become “certified” - with no qualifying warning, such as “certified but not child-friendly.”

*Pages 13715 - 13716*

**Comment:** TMA recommends that the “laboratory test results” requirement be removed from Stage 1 and Stage 2 criteria.

**Rationale:** Many EHRs do not yet have a patient portal module available and many patients do not have access to a computer and/or the internet to access information on the patient portal. Therefore, many times a physician needs to provide the clinical summary to the patient at the end of the visit. If there are any pending lab results, this is not possible. It would be overly burdensome on the practice to incur the cost of mailing the patient summary.

**Comment:** TMA recommends that the threshold number of patients to receive clinical summaries be lowered.

**Rationale:** Many patients, especially elderly patients, do not use e-mail or computers. Also, many patients who do use computers refuse to enroll in the patient portal, despite attempts by the staff and doctors encouraging them to do so. Some physicians have brochures and ask every patient, but still many do not want to enroll. One physician even reported that his college patients, who are adept in using online technology, refuse to enroll in the practice’s EHR patient portal. Physicians cannot, and should not, badger patients to use on-line access to their health information. Patients have complained that they do not like pressure from the practice staff to access their health information and communicate with the staff online.

*Pages 13717 - 13718*

*Proposed objective:* Incorporate clinical lab-test results into Certified EHR Technology as structured data.

**Comment:** From the EP perspective, it should be “doable” for EHRs to capture the number of results that are expected for each type of test ordered. For example, when EP orders “Lytes II”, the EHR product should be configured in such a way that this individual order is linked to five discrete results: Na, K, Cl, CO2, Glucose. The EHR should include a configurable attribute for each lab order that links the number of expected results to each order. So, one Lytes II order is then linked to 5 expected results. This built-in attribute will enable a report to create a 1:1 ratio of “#orders : #results” even if panel orders are entered. An EHR product would ideally include this as a standard report.

*Page 13718*

*Proposed EP Objective:* Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.

*Proposed EP Measure:* More than 10 percent of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder per patient preference.

**Comment:** TMA believes this is not an appropriate measure.

**Rationale:** Physicians with young adult populations who only need to be seen every two to three years for preventive visits would not fall into this category. Physicians such as surgeons, dermatologists, urologists, etc... may only treat patients for a one-time condition that requires no follow-up care. If CMS keeps this measure, there should be exclusions for certain specialties and patient populations.

*Pages 13718 - 13720*

*Proposed EP Objective:* Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

*Proposed EP Measure #2:* More than 10 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.

**Comment:** TMA strongly opposes physicians being measured, incentivized, or penalized based on the actions of patients that are beyond the physician’s control and, therefore, recommends this measure be eliminated.

**Rationale:** The goal of this objective is social engineering—that is, achieving this objective requires doctors to make patients do something. There is no objective evidence to show that improved outcomes will be the result of physicians’ actions to change patients’ behavior in the proposed manner. Without such evidence, it is not reasonable for CMS to base financial incentives or penalties on a physician’s ability to socially engineer this particular patient behavior. Many physicians treat elderly patient populations and it is not reasonable to expect these patient to have access to a computer and the internet to download or transmit information, much less the desire to do so. If CMS desires patients



to behave a certain way, the incentives should be for those patients. It should not be required of physicians.

*Pages 13720 - 13721*

*Proposed Objective:* Use clinically relevant information from Certified HER Technology to identify patient-specific education resources and provide those resources to the patient.

We also recognize that providing education materials at literacy levels and cultural competency levels appropriate to patients is an important part of providing patient-specific education.

**Comment:** TMA believes that to support this objective, EHRs should support patient discharge instructions that incorporate diagnoses or condition specific information.

*Pages 13722 - 13723*

*Proposed Objective:* The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

*Proposed Measure #2:* The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using Certified HER Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals.

**Comment:** TMA has concerns with EPs' ability to meet proposed measure #2. Until it has been verified that significant enough number of organizations have the ability to transmit summary of care record across different EHR platforms, this measure should be changed to only include those with the capability to do so. Once that occurs, TMA would have no issue with the use of this measure. Perhaps the use of a clearinghouse would make this more feasible.

**Comment:** Do not make "goals" a required element in the clinical summary care plan.

**Rationale:** The care plan definition is hospital-oriented and will be confusing to EPs. It would be simpler to define care plans as the "discharge instructions" for EPs. This is a much more familiar term. These instructions are already commonly provided at the conclusion of an office visit. The desired elements of the care plan as defined can be used to define the elements of the discharge summary.

TMA does not believe the EP's should provide patients with specific outcome goals because they become part of the medical record and could easily be misused in medical liability cases. Although outcome goals may be useful as a guide to patient management, they are often based on general knowledge or experience. They are not based on the unique characteristics of the individual patient and cannot possibly account for unanticipated changes in the unique patient's condition in the future. As a patient's condition changes the expected outcome goals will often change as well. Nevertheless, malpractice lawyers will find fertile material in any outcome goals documented in a medical record during depositions and trials.

Some chronic medical conditions and diagnoses do have consensus management guidelines including measurable outcome goals. Sometimes physicians may decide that a patient would benefit from educational resources that include outcome goals as a part of the educational resources provided (i.e. a list of diabetic care goals). Rather than requiring physicians to provide outcome goals to patients and increase their liability risks, it would be more valuable for CMS to focus on incentivizing EHR vendors (through EHR Certification) to develop products with clinical decision support tools to aid in the management of chronic medical problems and diagnoses that have consensus outcome measures and to incentivize physicians (through MU program) to use those CDS tools to achieve the desired outcomes. This could potentially lower the cost of healthcare by driving physicians toward adoption of best practices and reducing variability without introducing factors that could increase physicians' liability risk.

The goals during an office visit are to establish the diagnoses and determine the most appropriate care plan going forward. These goals are communicated to the patient through discharge instructions which include the working diagnoses and patient instructions. The patient instructions include any recommended tests or procedures, referrals, recommended treatment, medications prescribed, goals, educational resources if appropriate, future appointments and reasons to return. For EPs it should be sufficient to define the care plan as these discharge instructions. The goal for common sick or injury visits is for the patient to return to their baseline "wellness" which should not be required to be stated in discharge instructions.

Finally, in ONC's description of a "care plan" they specifically state that "We do not believe it would be appropriate for an EP to charge the patient a fee for providing the summary." This sentence should be struck. Although CMS does decide whether or not to pay for certain services, it should not dictate to physicians whether or not reasonable fees can be charged. Physicians should be free to decide whether or not to charge a fee for their time spent using secure messaging to communicate with patients. This technology is an added physician's overhead cost as it requires administrative resources to maintain and can involve physician time using. If the physician offers a pay-for-secure messaging service, the physician should be allowed to send the electronic summary through that service. For patients who decline to pay fees for secure messaging provided by their doctor, the proposed rule still requires physicians to provide the electronic summary through another acceptable modality.

Pages 13726-13727

*Proposed Objective:* Imaging results and information are accessible through Certified EHR Technology.

**Comment:** Local imaging centers may or may not offer online images to physicians and if they do, they may not allow an exchange of the images. TMA believes that imaging centers should be encouraged to provide online access and exchange of images but it is not reasonable at this time to require EPs to do so.

*Proposed EP Measure:* A secure message was sent using the electronic messaging function of Certified HER Technology by more than 10 percent of unique patients seen by the EP during the EHR reporting period.

**Comment:** TMA strongly opposes physicians being measured, incentivized, or penalized based on the actions of patients that are beyond the physician's control and, therefore, recommends this measure be eliminated.

**Rationale:** The goal of this objective is social engineering—that is, achieving this objective requires doctors to make patients do something. There is no objective evidence to show that improved outcomes will be the result of physicians' actions to change patients' behavior in the proposed manner. Without such evidence, it is not reasonable for CMS to base financial incentives or penalties on a physician's ability to socially engineer this particular patient behavior. Many physicians treat elderly patient populations and it is not reasonable to expect these patient to have access to a computer and the internet to download or transmit information, much less the desire to do so. If CMS desires patients to behave a certain way, the incentives should be for those patients. It should not be required of physicians.

#### Proposed Clinical Quality Measures for Eligible Professionals Beginning With CY 2014

We are proposing two reporting options that would begin in CY 2014 for Medicare and Medicaid EPs, as described below: Options 1 and 2. For Options 1, we are proposing the following two alternatives, but intend to finalize only a single method:

- Option 1a: EPs would report 12 clinical quality measures from those listed in Table 8, including at least 1 measure from each of the 6 domains.
- Option 1b: EPs would report 11 “core” clinical quality measures listed in Table 6 plus 1 “menu” clinical quality measure from Table 8.

**Comment:** TMA strongly favors Option 1b, as it best aligns with the primary goal of meaningful use Stage 2 (as stated on page 13702-13703) to “encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible.”

**Rationale:** The NPRM points out that Option 1a will provide more data on individual measures and therefore aggregated data will be more accurate, but at the risk of more physicians reporting un-meaningful “zeros” because their unique patient populations do not fit with the 12 selected measures. Option 1b, on the other hand, will enable more physicians to enter actual measures, but at the risk of less data on each individual measure when aggregated by CMS. TMA believes that the risk of the first option (less physicians reporting meaningful measures) is a greater threat to the primary stated goal of Stage 2 than the risk of the second option (less accurate aggregated data on individual measures).

*Pages 13757 - 13759*

We are considering an “interim submission” option for Medicare EPs who are in their first year of Stage 1 and who participate in the Physician Quality Reporting System. Under this option, EPs would submit the Physician Quality Reporting System clinical quality measures data for a continuous 90-day EHR reporting period, and the data must be received no later than October 1 to meet the requirements of the EHR Incentive Program. The EP would report the remainder of his/her clinical quality measures data by the deadline specified for the Physician Quality Reporting System to meet the requirements of the Physician Quality Reporting System. We request public comment on this potential option. Medicare EPs who are beyond their first year of Stage 1 and who choose the Physician Quality Reporting System EHR reporting option (Option 2 in section II.B.4.(c). of this proposed rule) must report in the form and manner specified for the Physician Quality Reporting System (for more information on current reporting requirements, see the CY 2012 Medicare Physician Fee Schedule final rule with comment period (76 FR 73314)).

**Comment:** The harmonization of clinical quality reporting requirements from different CMS programs as provided through this reporting method is much appreciated.

*Pages 13758, 13765 - 13766*

We also seek public comment on a group reporting option that allows groups an additional reporting option in which groups report for their EPs a whole rather than broken out by individual EP.

**Comment:** A significant problem for physician groups who have multiple physicians successfully attesting for Stage 1 Meaningful Use under just one TIN is that the Incentive awards are coming from CMS to the TIN in lump sums at different times. The lump sums are not linked to specific physicians or NPIs. As a result, practices are having a difficult time reconciling how much of the lump sum goes to each individual physician who successfully attested. The group reporting option may help address this issue. CMS should be aware of how important it is to link specific payment amounts to the specific physicians (i.e. their NPI numbers) who successfully achieve meaningful use.

*Pages 13768 - 13769*

**Comment:** TMA does not believe it is proper to tie Meaningful Use penalties (or lack of incentives) for behavior in a particular calendar year to required actions that would have to occur 91 or more days prior to the beginning of that calendar year.

### **Suggested Topics for Group Reporting Option Comments**

*Page 13766*

- Regarding the availability of Certified EHR Technology across the group, should the group be required to utilize the same Certified EHR Technology?

**Comment:** TMA believes it should be the goal for a group to utilize the same EHR, but there are problems with making it a requirement. Physician groups will be naturally incentivized to use the same EHR because the use and maintenance of multiple EHRs involves higher cost and greater complexities. There could groups who roll out new EHRs practice-by-practice. Early adopters of the EHR should not be penalized because the installation across all sites is not complete. CMS should avoid making this requirement and to let the inherent market and financial forces bring this goal to fruition naturally.

- Should a group be eligible if Certified EHR Technology (same or different) is not available to all associated EPs at all locations?

**Comment:** TMA would strongly oppose such a requirement. An EHR is sometimes rolled out office-by-office. Early adopters should not be penalized just because other offices have not been implemented yet.

- Should a group be eligible if they use multiple Certified EHR Technologies that cannot share data easily?

**Comment:** TMA opposes requirements that penalize physicians in a group that are early adopters of certified technology.

- With respect to EPs who practice in multiple groups or in a group and practice individually, how should meaningful use activities be calculated?

**Comment:** TMA believes physicians should be allowed to aggregate data for care provided to their own patient population through certified technologies. One way to accomplish this would be to link that data to their NPI.

- As the HITECH Act requires all meaningful users to be paid 75 percent of all covered services, how should the covered services performed by EPs in another practice be assigned to the group TIN?

**Comment:** TMA believes the primary EP should be accountable for the overall quality of care provided to his or her patients. Accordingly, the covering physician should be allowed to link those billed services to the NPI of the primary EP for the purposes of MU.

- How will meaningful use activities performed at other groups be included?
- Should these services be included in the attesting group, or should CMS just ignore this information or account for it in other ways?

**Comment:** TMA believes the patient's primary EP should be rewarded for providing quality care no matter how it is provided.

- How should the government address an EPs failure to meet a measure individually?

**Comment:** TMA believes that this is not an appropriate question to address at this immature stage of health IT tool usage and infrastructure. HIT stakeholders must first create an environment that realizes the potential value of EHRs by focusing on the promotion of widespread adoption and successful use of EHRs, development of robust HIE networks,

maturation of EHR product functionalities, and improved understanding of safe EHR usage before addressing the specific ways to leverage benchmark data and physician profiles.

- If an EP chooses not to participate in a particular objective should they be a meaningful EHR user under the group if their non-participation still allows group compliance with a percentage threshold?

**Comment:** If CMS intends to send lump sum payments to groups who achieve Stage 2 MU, then TMA recommends that the groups should be allowed to disperse the money as it sees fit and all physicians in the group should be deemed meaningful users. However, if CMS intends to send payments directly to participating physicians, then TMA recommends that the group should identify those physicians (using their NPI) at the time of their submission for MU payments.

Thank you for the opportunity to comment on the proposed rule. Should you have any additional questions or need any further information, please do not hesitate to contact us, Shannon Moore, 512-370-1411, or Jeff Gdula, 512-370-1344, Texas Medical Association.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph H. Schneider". The signature is fluid and cursive, with a large initial "J" and "S".

Joseph H. Schneider, MD, MBA  
Chair, *ad hoc* Committee on Health Information Technology