June 15, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: (CMS-3311-P; 80 FR 20345) Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Modifications to Meaningful Use in 2015 Through 2017; Comments of the American College of Radiology

The American College of Radiology (ACR)—a professional organization representing more than 35,000 radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists—appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) "Electronic Health Record Incentive Program - Modifications to Meaningful Use in 2015 Through 2017" Notice of Proposed Rulemaking (NPRM) published in the *Federal Register* on April 15, 2015 (CMS-3311-P; 80 FR 20345). The following comments were compiled by the ACR Commission on Informatics-Government Relations Committee.

General Comments

Create Attestation-Based Alternative for Hospital-Based EP Determination

ACR continues to recommend that CMS implement an optional attestation-based alternative process for EPs predominantly located in hospitals to obtain a "hospital-based" determination, and therefore ineligibility for the program and its associated penalties. Please see the ACR/Radiology Business Management Association's letter from 2013 for additional information about this recommendation: http://www.acr.org/~/media/ACR/Documents/PDF/Advocacy/Fed%20Relations/Meaningful%20Use/acr_rbma_cmsmu_11212013.pdf.

Combining Stage 1 and 2

ACR supports CMS' proposal to move to a consolidated stage of MU with flexibility for participants who would have otherwise been in Stage 1 prior to the changes from this rulemaking. We generally support

CMS' efforts to reduce the number and complexity of MU participation requirements, as this would simplify the regulations and increase participation.

Reporting Periods in 2016 and Beyond

ACR recommends that CMS implement a 90-day EHR reporting period for all MU participants in 2016 and beyond. This would increase overall participation and reduce the disrupting impact of MU planning and compliance on participants.

Clinical Quality Measures (CQM) Reporting

ACR recommends that PQRS participation using a Qualified Clinical Data Registry (QCDR) fully satisfy all CQM reporting requirements for MU. QCDR participation, in and of itself, should substitute for MU CQM reporting regardless of which specific CQMs are reported via the registry. This would significantly increase the applicability of the CQM reporting requirements in MU to non-primary care specialists, promote participation in QCDRs, and encourage more registries to seek QCDR recognition.

Add Scope of Practice-Based Measure Exclusions

ACR recommends that CMS include exclusions or alternative exclusions for "EPs who do not believe the measure is within their scope of practice" for all MU objective measures except for the proposed 42 CFR 495.22(e)(1) on security risk analyses and updates. This would dramatically increase the flexibility of the program and reduce the disproportionate regulatory burden of MU on specialist EPs.

Proposed Timeline for Attestation System/Processing Changes

We are concerned by CMS' proposal to temporarily attribute penalties to first-year MU participants who attested in 2016 for their CY 2015 reporting period due to anticipated delays in updating CMS' online attestation system. While we understand 2016 Medicare payments would be reconciled for these new MU participants whenever their attestations for CY 2015 are processed, we believe this is an exceedingly intrusive approach to the situation. CMS should instead consider not penalizing EPs in 2016 until all CY 2015 attestations are processed by the updated system.

Specific Comments

42 CFR 495.22(e)(2) – Clinical decision support

ACR recommends that CMS clarify in the preamble of the final rule that appropriate use criteria-guided clinical decision support (CDS) for EPs who order imaging, as outlined in section 218 of the Protecting Access to Medicare Act of 2014, could also be used to satisfy the MU CDS objective. This explanation was provided in the preamble of the NPRM for Stage 3, but not in the 2015-2017 NPRM.

42 CFR 495.22(e)(3) – Computerized provider order entry (CPOE)

ACR recommends that CMS clarify in the preamble of the final rule that EPs can exclude "protocol" or "standing orders" from the denominators of the measures under the CPOE objective. This explanation was provided in the preamble of the NPRM for Stage 3, but not in the 2015-2017 NPRM.

In the future, CMS and ONC should work with national organizations, the radiology CPOE/CDS industry, and others to identify standards to enable electronic transmission of diagnostic imaging orders to rendering providers. Ordering physicians who use CEHRT provided by a hospital or health system under the EHR exception/safe harbor from self-referral/anti-kickback requirements should also be fully enabled to order imaging electronically from rendering providers in the region who are not affiliated with the hospital or health system.

42 CFR 495.22(e)(4) - Electronic prescribing (eRx)

ACR supports the exclusion from the proposed eRx measure for "EPs with fewer than 100 permissible prescriptions during the EHR reporting period."

Additionally, ACR recommends that "protocol" or "standing orders" for medications not be used in the denominator of the eRx measure, as proposed for the computerized physician order entry (CPOE) measures in the Stage 3 MU NPRM. This change would improve continuity between MU in 2015-2017 and Stage 3 MU.

42 CFR 495.22(e)(5) - Summary of care

ACR supports the proposed exclusion for "EPs who transfer patients to another setting or refer patients to another provider less than 100 times during the EHR reporting period." We also recommend adding a new exclusion for "EPs with no office visits during the reporting period."

42 CFR 495.22(e)(6) - Patient specific education

ACR supports the proposed exclusion from this measure for "EPs with no office visits during the EHR reporting period" as this would increase the flexibility of MU and reduce the regulatory burden for certain specialists.

42 CFR 495.22(e)(7) - Medication reconciliation

It is unclear from the NPRM if CMS intends to limit the denominator of this proposed measure to transitions of care, or if certain referrals would also continue to be included as was the case prior to this rulemaking. If first time encounters with referred patients and referred patients accompanied by summary of care records continue to be included in the denominator, ACR recommends that CMS explicitly exclude referrals for imaging services from the denominator. A diagnostic radiologist EP should not be required to perform medication reconciliation if that data is not helpful for the medical service provided to the patient.

Additionally, ACR recommends that CMS revise the proposed exclusion from this measure to exclude "EPs for whom the total number of received transitions/referrals during the reporting period is less than 100." This exclusion was in the proposed Stage 3 version of this objective, but the 2015-2017 NPRM version does not give a buffer of 100.

42 CFR 495.22(e)(8) - Patient electronic access

ACR recommends adding new exclusions from both proposed measures of this objective for "EPs with no office visits during the reporting period" as this would increase the flexibility of MU and reduce the regulatory burden for specialists. To be clear, ACR strongly supports patient access to their own health information; and with this priority in mind, ACR and others in the imaging community have focused on such efforts as the "Imaging 3.0" initiative (http://www.acr.org/Advocacy/Economics-Health-Policy/Imaging-3), the Radiological Society of North America's "Radiology Cares" campaign (http://rsna.org/Radiology_Cares/), the ACR and RSNA's patient-facing resource RadiologyInfo.org, and more. However, the two proposed measures for this objective are focused on data elements and resources that are primarily managed by non-radiology providers. Therefore, it is appropriate to not require radiologists to duplicate access to the specific data elements maintained and provided by the primary care professionals who are coordinating the patients' care.

Additionally, ACR supports the proposed change to the second measure that "at least 1 patient" (instead of a certain percentage) seen by the EP during the EHR reporting period views, downloads, or transmits his or her health information to a third party. Eliminating the minimum percentage approach from the old rule would still ensure the functionality is being used without holding the EP responsible for patient actions outside of the clinical setting. This would be particularly important for referral-based specialists, such as radiologists, who have relatively limited opportunity to convince patients to complete the measured actions required under the second measure. Family physicians and other providers who see and communicate with their patients on a regular, re-occurring basis are more likely to be successful in promoting follow-up action by a percentage of their patients. Thus, the proposed change from a percentage-based measure to a functionality measure of "at least 1" is appropriate and necessary.

42 CFR 495.22(e)(9) - Secure messaging

ACR supports the exclusion from this proposed measure for "EPs with no office visits during the EHR reporting period" as this would increase the flexibility of MU and reduce the regulatory burden for certain specialists.

ACR also supports the proposed change from a percentage-based measure to a "functionality enabled" measure. This would ensure the functionality exists for office-based physicians if secure messaging would be useful to their patients, without mandating that a certain percentage of patients be messaged regardless of clinical purpose or utility.

42 CFR 495.22(e)(10) - Public Health and Clinical Data Registry reporting

ACR supports the proposed measures and exclusions for this objective, as well as the new flexibility to choose multiple registries of certain types to satisfy MU requirements. However, we recommend that CMS and/or ONC work expeditiously to publicly clarify acceptable methods for CEHRT data submission to clinical data registries.

As always, ACR welcomes the opportunity for continued dialog between the radiologist community and CMS regarding the EHR Incentive Program and health IT policy in general. Please contact Michael Peters, ACR Director of Legislative and Regulatory Affairs, at 202-223-1670 | mpeters@acr.org if you have questions or we can be of further assistance.

Sincerely,

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