May 28, 2015

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

Subject: (CMS-3310-P; 80 FR 16731) Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 Proposed Rule; 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) EHR Incentive Program-Stage 3 Notice of Proposed Rulemaking published in the *Federal Register* on March 30, 2015 (CMS-3310-P; 80 FR 16731). 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.

Single Stage of MU with Fewer Objectives

ACR supports CMS' proposal to move to a single "stage" of fewer EHR Incentive Program participation requirements. We agree that this proposal will reduce complexity for larger groups of eligible professionals (EPs) by eliminating the possibility that some EPs in the same group/practice could be in different MU stages. We also agree that reducing the total number of MU participation requirements will increase overall program participation by physicians, particularly in non-primary care specialties.

Yearlong Reporting Period for First-Year Participants

ACR does not support the proposal to move to a yearlong reporting period for all participants, including first-year participants in the Medicare version of the program. This would effectively move the MU compliance deadline up to January 1, 2018 for all EPs who are currently avoiding payment adjustments for noncompliance via significant hardship exceptions. Instead, the ACR recommends that CMS implement a 90-day reporting period for all MU participants every year. This would increase overall participation and reduce the disrupting impact of MU planning and compliance on future first-year participants.

Clinical Quality Measures (CQMs) and CQM Reporting Options

ACR supports CMS' proposal to promulgate future CQMs and CQM reporting options via the annual Medicare payment rulemakings (alongside PQRS requirements) instead of via standalone MU rulemakings. We agree this will enable CMS to more adequately align the CQMs and CQM reporting components of the Medicare incentive programs.

Moreover, we recommend that PQRS participation using a Qualified Clinical Data Registry (QCDR) also fully satisfy all CQM reporting requirements of MU. QCDR participation should substitute for MU CQM reporting regardless of which specific CQMs the QCDR can report to CMS. This would greatly 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 objective #1 (regarding 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.

"Certified EHR Technology" Definition

ACR recommends that CMS limit the "certified EHR technology (CEHRT)" definition to the 2015 Edition "Base EHR" criteria and any additional capabilities needed for demonstrating MU. The CEHRT definition should be as minimalistic as possible to enable various certified health IT modules to be meaningfully used without EPs needing to add unused capabilities to meet the "CEHRT" definition.

Specific Comments

42 CFR 495.7(d)(2)(i) – EP electronic prescribing

ACR supports the exclusion from the proposed Stage 3 e-prescribing (eRx) measure for EPs with fewer than 100 permissible prescriptions during the 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 Stage 3 computerized physician order entry (CPOE) measures. This would promote flexibility and consistency between the proposed CPOE and eRx measures.

42 CFR 495.7(d)(3)(i) – EP clinical decision support

ACR supports the proposed continuation of the clinical decision support (CDS) objective, as well as CMS' clarification in the preamble to encompass a wider variety of CDS functionality beyond basic pop-up alerts. We agree with the proposed clarification that appropriate use criteria for applicable imaging services, as outlined in section 218 of the Protecting Access to Medicare Act of 2014, should also be applicable to MU CDS measure requirements.

42 CFR 495.7(d)(4)(i) – EP CPOE

ACR supports the clarification to expand "radiology" orders to encompass all "diagnostic imaging" orders. Given the scope of the associated HIT certification criterion, we believe that program participants do not generally differentiate between "radiology" and "diagnostic imaging" orders as described by CMS' proposed rule.

Moreover, 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.

ACR supports the exclusion of "protocol" or "standing orders" from the denominators of the measures under this objective. We recommend that CMS also exclude protocol and standing orders from the denominator of the electronic prescribing objective/measure under 42 CFR 495.7(d)(2)(i).

42 CFR 495.7(d)(5)(i) – EP patient electronic access to health information

ACR supports the proposed exclusions from both measures 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 proposed measures for 42 CFR 495.7(d)(5)(i) are focused on data elements and resources that are primarily managed by non-radiology providers (i.e., the Common Clinical Data Set). 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.

42 CFR 495.7(d)(6)(i) – EP coordination of care through patient engagement

ACR supports the proposed exclusions from all three measures for EPs with no office visits during the reporting period as this would increase the flexibility of MU and reduce the regulatory burden for certain specialists. The proposed exclusions are particularly important for referral-based specialists, such as diagnostic radiologists, who have relatively limited opportunity to convince patients to complete

the measured actions. 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.

For the first proposed measure (495.7(d)(6)(i)(B)(1)) requiring more than 25 percent of unique patients seen by the EP actively engage with the EHR or access via an API, ACR recommends that CMS reduce it to a specific, small number (such as 1 or 5) as was proposed in the separate rulemaking to reform MU in the years 2015 through 2017. This would reduce EPs' reliance on patients to complete certain actions with their access under 42 CFR 495.7(d)(5)(i), and eliminate one of the major compliance barriers to meeting the current Stage 2 MU requirements.

For the second proposed measure (495.7(d)(6)(i)(B)(2)) that more than 35 percent of unique patients seen by the EP are sent a secure message using the CEHRT electronic messaging function, the ACR recommends that CMS instead require that secure messaging functionality simply "be enabled," as was proposed in the separate rulemaking to reform MU in the years 2015 through 2017. This ensures that the functionality exists for physicians who have office visits 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.

For the third proposed measure (495.7(d)(6)(i)(B)(3)) that patient-generated data or data from a nonclinical setting be incorporated into CEHRT for more than 15 percent of unique patients seen by the EP, the ACR recommends that CMS instead require that the corresponding functionality "be enabled." This improvement would address the inevitable future compliance problems as experienced with the (pre-reform) MU Stage 2 measures that require a percentage of patients to take specific actions with the provided functionality.

42 CFR 495.7(d)(7)(i) - EP health information exchange

For the proposed second and third measures (495.7(d)(7)(i)(B)(2) and (B)(3)), the ACR recommends that CMS explicitly exclude referrals for imaging services from the denominator of "transitions or referrals received and patient encounters in which the provider has never before encountered the patient." A diagnostic radiologist EP should not be required to incorporate unneeded data and perform clinical reconciliation of the minimum medication, medication allergy, and current problem list data sets if the information is not helpful for the medical service provided to the patient. The ACR seeks explicit clarification of the denominator such that referrals for imaging would not be included. Additionally, ACR supports the proposed exclusions from these measures for EPs for whom the total number of received transitions/referrals is less than 100.

Although ACR recommends excluding imaging referrals from the denominators of the second and third measures, we do support the intent of the proposed first measure for EPs who transition/refer patients to another provider. Referring physicians should be encouraged to exchange summary of care records with all providers to whom they refer patients. Then, it should be up to the receiving provider what to do with the data elements from the summary of care record.

In response to CMS' question in the NPRM preamble regarding who should reconcile the data, ACR recommends that CMS not specify categories of professionals or minimum licensure requirements in the final rule. The decision of who should centrally administer this and other MU requirements on behalf of participating EPs should continue to be up to offices/groups/practices, and should be as flexible as federal and state rules will allow.

42 CFR 495.7(d)(8)(i) - EP Public Health and Clinical Data Registry: Reporting objective

ACR supports the proposed objective, measures, and exclusions under CFR 495.7(d)(8)(i); however, we recommend that CMS and ONC work expeditiously to clarify via the final rule or future guidance the minimum requirements that specialized registries would need to determine if they could be identified as "ready" clinical data registries in CMS' future registry repository. The CMS' and ONC's 2012 rules left unresolved the question of what minimum standards are needed to support connectivity between CEHRT and specialty societies' registries under the "specialized registry" MU Stage 2 menu set objective. This confusion must be resolved quickly so that the specialty societies with registries who wish to facilitate their participants' MU compliance can take appropriate steps to do so.

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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