June 15, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3311–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017

Dear Administrator Slavitt,

On behalf of the 13,500 U.S.-based members of the American Academy of Dermatology Association (AADA), I am writing to provide comments to the Centers for Medicare & Medicaid Services’ (CMS) proposed rule, Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017, dated April 15, 2015. The AADA is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We appreciate the opportunity to provide comments on the proposed changes to the Electronic Health Records (EHR) Incentive Program for 2015 through 2017, as well as comments on the areas in which we believe the program could be further improved to meet the needs of both physicians and their patients. We hope that CMS will take these recommendations and concerns into consideration as it finalizes this proposed rule.

General Comments

The AADA believes that the proposed rule helps move the EHR Incentive Program in the right direction toward greater flexibility, less confusion, and more realistic targets for providers. The AADA recognizes CMS’ hard work in this area, and appreciates CMS’ effort to respond to physician concerns about the EHR Incentive Program and the difficulty many physicians encounter in trying to complete the measures for meaningful use. While the AADA still believes that the EHR Incentive Program could be further improved, we support aspects of the proposed rule and the positive changes it would make to the program.

Stages of Meaningful Use
In the proposed rule, CMS asks whether it should provide an option of demonstrating Stage 3 in 2017, or wait until 2018 to let providers begin Stage 3. The AADA supports the flexibility of permitting providers to demonstrate Stage 3 in 2017 and making it optional. This provides physicians and other providers with the choice of tailoring the program to their individual progress implementing the EHR program requirements in their practices.

**Reporting Period**

The AADA strongly supports CMS’ proposed change to the EHR reporting period in 2015, which would allow physicians to attest to an EHR reporting period of any continuous 90-day period during the calendar year. Furthermore, we support CMS’ proposal to also permit a 90-day EHR reporting period in 2016 for physicians demonstrating meaningful use for the first time.

This proposed 90-day reporting period is precisely the type of flexibility that permits physicians to participate fully in the EHR Incentive Program. It reduces an administrative burden on physicians while still maintaining a strong commitment to the use of Certified Electronic Health Records Technology (CEHRT) in physicians’ offices. For this reason, the AADA encourages CMS to move further toward ensuring maximum physician success and participation, and permit a physician to attest to a continuous 90-day period for all Stages of the program moving forward. The AADA sees no compelling reason to require providers to attest to an EHR reporting period of an entire calendar year when a continuous 90-day period accomplishes the same goal with significantly less hardship for the providers.

**“Topped Out” Measures**

The AADA applauds CMS’ work to remove measures deemed to have become redundant or duplicative, i.e. “topped out,” from the EHR Incentive Program. We appreciate that physicians would have eleven fewer measures to which they would need to attest, particularly given the repetitive nature of those removed measures. We encourage CMS to continue to refine the objectives and measures it requires for the meaningful use program, and continue to remove program requirements that no longer serve the purpose for which they were created.

Furthermore, the AADA suggests additional measures for CMS to include in its list of “topped out” measures. We believe, and CMS data confirms, that the measures for e-prescribing and medication reconciliation appear to also be “topped out.” Eligible providers (EPs) have met both of these measures at very high rates. According to CMS data, 83% of the EPs in the first quartile have successfully attested to the e-prescribing measure, 92% in the second
quartile, and 96% in the third quartile.\(^1\) CMS data also shows EPs meeting the measure for medication reconciliation at or above 90% for all quartiles.\(^2\)

We believe that this demonstrates that these measures have “topped out” and should be removed from the EHR program reporting requirements.

**Patient Engagement Objectives**

The AADA appreciates CMS’ proposal to modify the Stage 2 objectives that rely on patients’ actions. We have consistently argued that it is neither a fair measure of physicians’ efforts to meet program requirements nor a true assessment of how well providers are meeting the EHR Incentive Program’s goals. While physicians can educate and encourage their patients to engage in certain behaviors, it is the patients themselves who control their own actions.

The AADA supports the removal of the five percent threshold for the “patient action to view, download, or transmit health information” measure, and its replacement with a requirement that at least one patient must view, download, or transmit health information to a third party. This new proposed measure would still accomplish the goal of ensuring that CEHRT is fully operational, but would not penalize a physician for his or her patients’ actions (or lack of actions).

The AADA also supports the threshold change for the “secure electronic messaging” measure from five percent to a “yes-no” measure stating the functionality was fully enabled. We agree with CMS that this modification allows providers to work toward engaging patients in a way that respects each individual physician’s practice and patient population. Moreover, it does so while still remaining consistent with the EHR program’s true goal of providing fully-enabled and secure electronic messaging.

These efforts are an important part of the proposed rule. These proposed modifications help the EHR program maintain a balanced approach by recognizing the limits that physicians and other providers have with respect to influencing the actions of their patients, and yet still requires the full functionality of CEHRT. The AADA hopes that CMS will continue to maintain this reasonable balance as it moves forward with Stage 3 of the EHR Incentive Program.

**Summary of Care**

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\(^2\) Id.
The AADA agrees with CMS’ assessment of the difficulty of sending a summary of care record electronically due to the lack of an interoperability infrastructure. We applaud CMS for changing the technical specifications for this measure to simply sending the summary of care record electronically rather than through an approved health information exchange platform. We ask, however, for further clarification regarding this proposal. Would CMS allow physicians to send a summary of care record via email if the email is HIPAA-compliant? Also, would it count in the numerator of this measure if the recipient’s email address is not HIPAA-compliant?

Additionally, we strongly recommend that CMS include an additional exemption to this measure for providers who send referrals to other practices that have not implemented the EHR program. Many dermatologists have a small subset of physicians to whom they send referrals, and many of these include practices that have not implemented the EHR program. Thus, these physicians are unable to send summary of care records electronically regardless of their efforts to comply with the program’s requirements. We would appreciate CMS creating an additional exemption for these physicians, who are simply unable to meet this measure due to the lack of EHR adoption by other providers.

**Meaningful Use Objectives and Measures for 2015 through 2017**

The AADA appreciates CMS’ work to move Stages 1 and 2 for EPs into a single set of nine proposed objectives, and one consolidated public health objective, thus creating a new and simplified structure. This simplification should make it easier for physicians to implement the EHR program requirements in their practices and understand what the program requires of them over time since the objectives and measures will not necessarily change as physicians move through the progressive Stages of the program.

Additionally, the AADA supports CMS’ proposal to maintain the specification for objectives and measures that have a lower threshold or other measure in Stage 1 than in Stage 2. So for those providers who are scheduled to attest to Stage 1 in 2015, they may attest to the Stage 1 measures rather than the Stage 2 measures where there is a difference in specifications. This flexibility will help to ensure that more providers are able to meet the EHR Incentive Program goals and help to move more physicians toward full and successful program participation.

The AADA also supports CMS’ proposal to exclude Stage 2 measures that do not have an equivalent Stage 1 measure, and to exclude Stage 2 measures if the provider did not plan to attest to the menu objective that would not now be required under the proposed rule. The AADA applauds CMS’ work to simplify
the requirements between Stages 1 and 2 and to ease the reporting burden for providers as they work to satisfy the objective and measure requirements.

The AADA encourages CMS to continue to look for ways to streamline the EHR Incentive Program and make compliance less burdensome for physicians. We believe that this proposal moves the program closer to a space that recognizes the significant challenges and resource expenditures that physicians must make to comply with the program and not face penalties. Nevertheless, further changes and modifications could be made to the EHR Incentive Program that would permit CMS to still meet the program’s goals, but also make the program a realistic one for physicians. As we suggested above, we believe that CMS should extend the proposed reporting period modification of 90 days beyond the EHR reporting period for 2015. Moreover, we also believe that any measurement of patient engagement needs to rely on actions within the providers' control, i.e., making a system operational, but not measuring the independent actions of a patient. These are the kinds of steps CMS can continue to take throughout each program Stage to ensure a robust EHR program with strong physician participation.

**Hardship Exemptions**

While the AADA supports the current hardship exceptions in meaningful use for providers, the AADA does not believe that these exceptions are sufficient as they do not include many physicians who truly struggle to meet the program’s requirements. We reiterate our support for an exception for physicians in solo practice and providers who are beyond retirement age as defined by the Social Security Administration. In fact, in the Academy’s annual survey of its members, we found that 65% of respondents close to retirement age found “pressures to implement EHR” to be a significant factor in their decision to retire. For these physicians in particular, the program requirements are simply too costly and time-consuming to implement given the providers’ brief period in which they would need to meet the EHR program requirements.

**Clinical Quality Measures (CQMs)**

The AADA appreciates CMS continuing to allow providers the option of either attesting or reporting the CQMs electronically in 2015, 2016, and 2017. We also encourage CMS to continue this option after 2018 and not require physicians to report CQMs electronically since there are no dermatology measures that currently have e-specifications developed. Since CMS is also continuing to require attestation as a reporting method for the other meaningful use measures, we believe CMS should also allow attestation for the CQMs to ensure there is a singular reporting method for physicians.

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3 The American Academy of Dermatology, Dermatology Practice Profile Survey 2014 Findings, March 2015.
Additionally, we seek clarification from CMS as to whether physicians will continue being able to report zero numerators and/or denominators for CQMs since there are no CQMs relevant to dermatology.

Conclusion

The AADA appreciates the opportunity to provide comments on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017 proposed rule. We look forward to additional opportunities to discuss these issues and to provide feedback that may help guide policy development. Please contact Amanda Pezalla, JD, Manager, Regulatory Policy, at (202) 842-3555 or APezalla@aad.org if you require clarification on any of the comments in this letter or would like more information.

Sincerely,

Mark Lebwohl, MD
President, American Academy of Dermatology Association

CC: Elaine Weiss, JD, Executive Director
    Barbara Greenan, Senior Director, Advocacy and Policy
    Leslie Stein Lloyd, JD, Director, Regulatory and Public Policy