AMA
AMERICAN
MEDICAL
ASSOCIATION

**Michael D. Maves, MD, MBA,** Executive Vice President, CEO

September 17, 2009

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

The American Medical Association (AMA) strongly supports efforts to incorporate electronic health records (EHRs) into physicians practices to improve quality of care delivery as well as enhance practice efficiencies. Since the passage of the "American Recovery and Reinvestment Act of 2009" (ARRA), the AMA has actively engaged with the Office of the National Coordinator (ONC) and the Health IT Policy and Standards Committees, and recommended an achievable and predictable pathway toward meaningful use of EHRs, including a set of program specifications for meeting the 2011 incentive payment timeframe and beyond. Our proposal, which we developed after months of considerable, thoughtful deliberations with national specialty and state medical societies, enables eligible physicians in all sizes of practices and specialties to take advantage of the financial incentives authorized by the ARRA.

**The AMA is very troubled with the direction that ONC is taking based on the Policy Committee's aggressive, inflexible meaningful use objectives, measures, and reporting requirement recommendations and the tying of federal incentives to provider performance on outcomes-related quality measures. It is also imperative to realize that the ability of physicians and their practices to meet the goals outlined is dependent on the open and appropriate sharing of health information among providers of health care services. We are extremely concerned that the goal of widespread EHR adoption and use will be undermined if the majority of physicians determine that they will be unable to meet the 2011 Medicare EHR incentive program reporting requirements.**

Aggressive Timeframes

According to ONC's proposed matrix, eligible health care providers are required to use computerized physician order entry (CPOE) for all orders by 2011. Although this proposal may be reasonable for medications, this objective is unachievable today for most orders such as laboratory tests or diagnostic imaging given the fact that the electronic interfaces among systems used by health care partners do not readily exist.

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Another unrealistic 2011 objective is the requirement to report ambulatory quality measures to the Centers for Medicare & Medicaid Services (CMS). Before external reporting is required, physicians should first be able to create their own reports on a set of defined measures and patient populations. To ensure physicians are successful in submitting quality reporting information to CMS through an EHR, the CMS system must be able to handle such submissions and the EHRs must be able to transmit the data as directed. Under AMA's cardio HIT project, an Agency for Healthcare Research and Quality (AHRQ) funded project, the six practices that participated—all of which are sophisticated EHR users with dedicated IT staff—would not have been able to successfully submit data on performance measures to a centralized data warehouse had they initially been required to transmit data using the desired HL-7 format. Furthermore, physicians will not be able to meet ONC's proposed reporting requirements without incurring significant costs. Therefore, flexibility in the way measures are reported is necessary, and CMS should announce the measures they plan to use so that vendors have time to incorporate them into EHRs. We further believe that the 2013 proposal to require "specialists report to relevant external disease (e.g., cardiology, thoracic surgery, cancer) or device registries, approved by CMS" is too aggressive. While a few specialties are much further ahead and well-positioned than others (e.g., thoracic surgeons), most specialties would not be able to undertake these activities until 2015.

Finally, it is critical that any meaningful use specifications take into account the fast approaching federal IT mandates that will require physicians' and their health care partners to dedicate substantial time and resources to move to the new set of HIPAA electronic transactions (version 5010) required by January 1, 2012, and the move from ICD-9 CM to ICD-10 CM and ICD-10 PCS codes by October 1, 2013. Careful consideration must be given to ensure that physicians are not financially, technologically, and operationally overwhelmed with multiple, costly, complicated IT mandates and incentive programs (as well as looming penalties) that could significantly diminish the likelihood of EHR implementations. **While we recognize that the years for receipt of financial incentives are set in statute, we strongly urge HHS to provide the utmost flexibility on meaningful use specifications so that all physicians who would like to participate in the incentive program have the ability to do so beginning in 2011.**

Incentives Should Only be Tied to Quality Measure Reporting

To sustain a quality health care system, an interoperable, secure health IT network must be in place first. The capability to capture quality measure reporting to assess performance will require significant EHR use, programming, testing, training, and information exchange. Through the work of the AMA and others in the health care community, the capability to capture quality measure reporting is being developed now. **Therefore, adopting a proposal that immediately ties incentives to quality metric scores is premature; incentives must only be tied to the use of health IT to report on quality measures.**

*Integrating Performance Measures into EHR Systems Still Underway*

The AMA is working closely with the EHR vendor community and others to increase functionality in EHR systems that facilitate physician use of measures for quality improvement and reporting. The AMA, with the National Committee for Quality Assurance (NCQA), and the Health Information Management Systems Society's Electronic Health Record Association, continues to cosponsor the Collaborative for Performance Measurement Integration with EHR systems (Collaborative). The Collaborative is focused on facilitating the integration of performance measures into EHR systems to enable accurate translation of measures and to promote quality improvement. Procedural protections are needed, however, to ensure physicians and other clinicians can successfully submit data to a federal agency from a registry or EHR product. The incentive reporting requirements must take into account that time is needed to establish an interoperable, secure health IT network, fully operational EHRs with performance measure capabilities, health information exchange capabilities, along with active participation among all relevant health care partners in the exchanges.

*Quality Measures Inappropriate and/or Lacking for Some Specialties*

For physicians interested in attaining meaningful user status to qualify for the incentive payments, they will need to meet all the specifications outlined in the matrix adopted by the Health IT Policy Committee. The matrix does not, however, take into account whether all of the measures and specifications apply equally to every physician.

We are concerned that a "one-size fits all approach" will require all specialties to comply with measures and specifications that may be irrelevant for them. For example, reporting the percentage of diabetic patients with A1c under control is not something typically done by a dermatologist. Further, flexibility must be exercised on how these incentives are distributed as not all specialties and provider types currently have quality measures specified for capture under an EHR.

Since the inception of the Physician's Quality Reporting Initiative (PQRI) under CMS, a significant amount has been learned about quality measurement development and reporting. We should recognize the importance of establishing incentive program reporting requirements that are broad-based and achievable to encourage the widest possible adoption. The initiatives of the EHR Collaborative and the AMA-convened Physician Consortium for Performance Improvement® (PCPI) have allowed the AMA to be a leader in driving quality improvement, which has led to our engaging the Administration and Congress on various quality measurement and improvement programs and activities. **If HHS proceeds with a proposal that strictly ties the ARRA incentives to quality benchmarks, requires compliance with problematic measures and specifications, and fails to take into account that not all specialties have quality measures available for capture in EHRs, our collective goal of widespread health IT adoption and quality improvement at the point of care will be seriously compromised.**

Conclusion

Encouraging physician adoption of Health IT, especially small physician practices, is critical to ensuring widespread EHR use. Unrealistic timelines and criteria will only serve to undermine this effort. The AMA is deeply committed to significantly increasing EHR adoption. The AMA has supplied ONC with extensive comments regarding meaningful use. We urge the Administration to seriously consider the AMA's comments (attached is our last submission) before it proceeds with publishing the proposed rule with the definition of meaningful use. We are hopeful that the AMA can work with the Administration to develop regulations that truly foster EHR adoption. Should you have questions about these comments, they can be directed to Mari Savickis at mari.savickis@ama-assn.org or 202-789-7414.

Sincerely,

Michael D. Maves, MD, MBA

Attachment