May 7, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and 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

Dear Acting Administrator Tavenner:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to comment in response to the proposed rule published on March 7, 2012, on Stage 2 of the Electronic Health Record Incentive Program (EHRIP). AACAP joins other physician groups in expressing the greater physician community’s concerns with several parts of the regulations. AACAP has specific concerns about several proposed core and menu measures, as well as the timeline for the proposed rule, which could adversely affect psychiatrists’ ability to provide integrated care to their patients. In addition, we feel that some of the criteria will actually discourage physician participation in the program rather than encourage it.

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP’s members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

CMS’ Unauthorized Private Payer Data Use
We are extremely concerned that CMS has taken the position that physicians who are taking part in the Medicare or Medicaid meaningful use EHR incentive program are required to apply the meaningful use measures to their entire patient population, including their non-Medicare/Medicaid

3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
202.966.7300 800.333.7636
Fax 202.966.2891
Email: executive@aacap.org
http://www.aacap.org
patient population. The American Recovery and Reinvestment Act clearly sets parameters that the meaningful use EHR incentive and penalty programs are only based on Medicare charges and payments (not private payer charges and payments). CMS’ expectation that a physician meet meaningful use measures for all of their patients, but only receive incentives based on their Medicare patients is highly unfair for physicians who have more private payer business than Medicare business, and this approach is not supported in statute.

CMS’ decision also raises serious privacy concerns. A private payer patient (e.g., Blue Cross Blue Shield PPO patient) is not expecting that his/her confidential medical information can be disclosed to the federal government under the guise of the Medicare/Medicaid EHR incentive programs. According to the American Medical Association’s assessment of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, private payer patients would have to authorize the disclosure of their health information to CMS under the EHR incentive program as such a disclosure to CMS would not qualify under any of the HIPAA privacy rule exceptions (treatment, payment, or health care operations). Therefore, a private payer patient’s formal consent would be required if CMS requires the inclusion of private payer identifiable patient data in Medicare meaningful use reporting.

CMS should make it clear that physicians are NOT required to apply the Medicare/Medicaid meaningful use program requirements to their non-Medicare/Medicaid patient populations in order to be eligible for Medicare or Medicaid EHR incentives or in order to avoid Medicare financial penalties.

Stage 2 Meaningful Use Measure Proposed Requirements - Core Measures
AACAP remains concerned that some of the proposed Stage 2 core measures and their related exclusions cannot be satisfied by most psychiatrists or pediatricians, let alone child and adolescent psychiatrists. We request that CMS modify some of its proposed core measures and related exclusions so they better account for diverse practice settings and the unique patient population they treat. We ask that CMS revise or delete all Stage 2 meaningful use measures that are not entirely contingent solely upon a physician’s performance.

Proposed core measure for Stage 2: eRx
More than 65% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.

In the proposed rule, CMS suggests creating an additional measure for EPs to choose that would include controlled substance electronic prescriptions in the denominator. CMS acknowledges that while the Drug Enforcement Administration’s (DEA) interim final rule on electronic prescriptions for controlled substances removed the federal prohibition to electronic prescribing of controlled substances, more restrictive state laws and a lack of availability of products both for providers and pharmacies that include the functionalities required by the DEA’s regulations currently frustrate CMS’s capacity to create such a measure for EPs to use. CMS points out that the future creation of an additional measure may not be problematic as Stage 2 meaningful use would not go into effect until 2014. However, AACAP believes it is highly unlikely that current state laws prohibiting the electronic prescription of controlled substances will be overturned by 2014, thus diminishing the likelihood that the creation of a measure for eRx that includes controlled substance electronic prescriptions in the denominator would be achievable for most.
child and adolescent psychiatrists. We recommend additional exclusion criteria broad enough to
cover physicians who cannot meet the e-prescribing threshold due to individual hardship whether
this is psychiatrists who treat patients in settings where they issue the prescriptions or do not
have a certified EHR, physicians with a large volume of mail-orders, or large volumes of
controlled substances. Until the many challenges associated with e-prescribing are resolved, the
threshold for the e-prescribing measure should only be increased to 50 percent and psychiatrists
should have the discretion to review the drug formulary, if it is readily available.

Proposed Core Measure for Stage 2: Record demographics
More than 80 percent of all unique patients seen by the EP during the EHR reporting period
have demographics recorded as structured data.
We support the inclusion of the recording of gender identity and/or sexual orientation, disability
status, occupational demographics, etc., as optional information for physicians to record given
that the capturing of this data may be important for quality of care purposes for some specialties.
We urge CMS to provide as much flexibility as possible so that physicians have the discretion to
record information that they believe is clinically relevant to the care that they provide to their
patients. Particularly for information related to gender identity and/or sexual orientation a
physician must have discretion to determine if it is developmentally appropriate to query the
patient and to determine the appropriate point in the patient-physician relationship.

Proposed core measure for Stage 2: Record vital signs
More than 80% of unique patients seen by the EP during the EHR reporting period have blood
pressure (for patients 3 and over only) and height/length and weight (for all ages) recorded as
structured data.
We recommend that objectives related to recording vital signs be implemented as CQMs and not
as a measure of meaningful use of technology. Specialists should be able to select and report on
measures if determined to be clinically relevant. While recording previously defined vital signs
including height, weight, and blood pressure may not be routine practice within a typical
psychiatric outpatient visit, taking and recording some or all of a patient’s vital signs is relevant
to a psychiatrist’s scope of practice. We do not support the latter portion of this measure’s
exclusion language that reads, “EPs who believe that all 3 vital signs of height, weight, and
blood pressure have no relevance to their scope of practice.” A modification in the exclusion
language should be made so that child and adolescent psychiatrists who do not routinely take
some or all of a patient’s vital signs may exclude themselves from the measure. Requiring
physicians to attest to and/or report on metrics that are not clinically relevant to them and their
patients, or to every encounter with a patient, does not help improve quality or practice workflow

Proposed core measure for Stage 2: Clinical decision support
1. Implement 5 clinical decision support interventions related to 5 or more clinical quality
measures at a relevant point in patient care for the entire EHR reporting period, and
2. The EP has enabled and implemented the functionality for drug-drug and drug-allergy
interaction checks for the entire EHR reporting period.
AACAP does not support CMS’ proposed measure to require implementation of five clinical
decision support rules. The financial and staff resources associated with customizing these forms
and tools should be taken into consideration before requiring a threshold of five clinical decision
support rules be implemented in Stage 2. Moreover, the requirement to implement five clinical
decision support interventions related to five or more clinical quality measures would be challenging for sub-specialists like child and adolescent psychiatrists who may not need to implement so many clinical decision support interventions for their particular patient populations and given the specific type of care that they provide. EPs should only have to attest to implementing no more than two clinical decision support rules during the reporting period for Stage 2.

**Proposed core measure for Stage 2: Send reminders to patients.**

More than 10% 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.

We support CMS’ proposed measure for sending reminders to patients, but are concerned that the measure as written is inappropriately inflexible for many specialists particularly in mental health. Physicians should have the discretion to issue reminders in a variety of ways and the Stage 2 measure should be flexible enough to allow for reminders to be provided via phone calls, voice mail messages, emails, printed reminder notices provided after the initial visit, etc. For child and adolescent psychiatrists, there may be a larger percentage of patients requesting that no reminders be sent. Physicians should have the flexibility to implement method(s) that work best for the physician practice and the patient.

Additionally, AACAP does not support the requirement that physicians only focus the sending of reminders to patients seen 24 months prior to the beginning of the EHR reporting period. Some services are one-time consultative visits so there is no need to send a reminder to the patient for a follow-up visit. We recommend that the measure include an exclusion for physicians who do not routinely send reminders to their patients given the type of care that they provide.

**Proposed core measure for Stage 2: Provide patients with electronic access to their health information.**

1) More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information.

2) More than 10% 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.

While greatly supporting patients’ access to their health information, AACAP does not support the second part of this measure as being necessary to a physician achieving Stage 2 MU requirements. As a general principle, a physician’s performance of core measures should not be dependent upon actions being taken by the physician’s patients. This principle rings particularly true for psychiatrists whose successful treatment of a patient is largely dependent upon having the trust of their patients. Even in instances in which a psychiatric patient may be able to satisfy the second part of this measure, we question if a child and adolescent psychiatrist’s fulfillment of a quality measure based on the actions undertaken by his/her patient or family is questionable under the ethics code to which child and adolescent psychiatrists are bound. If fulfillment of this measure is viewed as primarily benefiting the physician, the second prong of this quality measure could potentially violate AACAP’s Code of Ethics (http://www.aacap.org/galleries/AboutUs/AACAP_Code_of_Ethics.pdf). Additionally, the
inclusion of a caveat that allows authorized representatives of a patient to facilitate the physician’s fulfillment of this measure will be unworkable for many child and adolescent psychiatrists. A great percentage of psychiatric patients are extremely protective of their relationship with their psychiatrist, including children and adolescents, who have developed a level of trust with the psychiatrist that could be damaged if they know their parents can access their information. State laws vary as to the level of medical autonomy children and adolescents have at different ages, so parents may not always have a right to access their child’s information.

We appreciate the acknowledgment of the need for clinician discretion in posting online patient information. This discretion is particularly necessary for child and adolescent psychiatrists as there will be times in which it is best for a psychiatrist to personally interpret a patient’s health information in person with the patient and/or family.

**Proposed core measure for Stage 2: Provide clinical summaries for patients.**

*Clinical summaries provided to patients within 24 hours for more than 50% of office visits.*

While we realize the benefits of having patients send electronic messages to their physicians, AACAP has serious concerns with how this measure has been modified from Stage 1 to Stage 2. Originally, as a Stage 1 measure, clinical summaries had to be provided to patients within 3 business days. A child and adolescent psychiatrist will likely need more than 24 hours following an encounter with a specific patient to make an informed decision as to what information should or should not be shared with the patient and/or family as part of the clinical summary. In some situations, the patient and/or family accessing the information without a clinician present to help interpret and respond to the results could pose potential harm. For patient cases necessitating a physician’s discretion, 24 hours is an insufficient period of time to determine whether the potential for patient harm is present. As currently written, this measure does not afford child and adolescent psychiatrists the time they need to ensure they act in the absolute best interests of their patients.

**Proposed core measure for Stage 2: Provide summary care record for each transition of care and referral.**

1) The EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65% of transitions of care and referrals.

2) The EP that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10% of transitions of care and referrals.

AACAP strongly opposes the inclusion of the second part of this measure in the list of core measures. As earlier stated, a physician’s accomplishment of Stage 2 should not be dependent upon variables beyond his/her control. When a patient’s summary of care is sent, the physician has no control over whether the recipient of the summary is of a different organizational affiliation and uses a different Certified EHR Technology vendor. For many physicians, this measure would be impossible to satisfy or even verify. It is already commonplace knowledge that some Certified EHR Technology vendors monopolize the entire marketplace of a specific geographic area. A physician sending a patient’s summary of care to a recipient in an exterior organization but within the same geographic area and thus likely within the same Certified EHR Technology marketplace and using the same vendor would not be able to satisfy this measure.
Proposed core measure for Stage 2: Use secure messaging.

A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10% of unique patients seen by the EP during the EHR reporting period.

This a new untested measure and we therefore recommend that the measure be placed in the menu set for Stage 2 and be modified so that the message is from the physician, not the patients. A physician’s ability to fulfill Stage 2 core measures should not be tied to actions taken by a physician’s patients. In particular, for a psychiatrist to be able to successfully treat a patient, the psychiatrist must not request that any patient perform an action solely for the benefit of a physician. For any number of reasons, including lack of ownership of a computer, lack of technological skills, or heightened anxiety, many patients with severe and persistent mental illness may not be capable of sending an electronic message. Additionally, some patients may not be comfortable having “relevant” medical information conveyed via electronic messaging, even if secure. In addition, for a child and adolescent psychiatrist, there are concerns about parental involvement with the health information of autonomous children or adolescents and the patient in this case is the child or adolescent not the adult or parent. In addition, an unintended consequence of promoting that patients send electronic messages to their physicians is that patients who may find themselves in a life-threatening situation may turn to email as a means of communicating with their physician, rather than attempting to immediately access their physician through the use of a telephone or pager or dialing 911. There are also legal concerns with this measure being in the core set given that emails are discoverable in lawsuits, and so physicians may want to limit e-mail communications with their patients that are not as comprehensive as a face-to-face meeting, a phone conversation, or non-email written communication.

Another point of concern is that physicians who bill Medicare are not reimbursed under current payment policies for email communications with patients. Physicians should not be forced to provide services that are not covered or non-billable under Medicare. Not only should this measure be placed in the menu set, but the measure should be modified and based on a physician’s (not the patient’s) issuance of electronic messaging.

Stage 2 Meaningful Use Measure Proposed Requirements - Menu Measures

Child and adolescent psychiatrists will only be able to meet the criteria of one menu measure: “Record patient and family information.” To complete performance of 3 of 5 menu measures, psychiatrists will have to satisfy the exclusion criteria of at least two menu measures, which would be possible. However, the language in the regulation that explains how a physician may fulfill menu measures is less clear than the language which explains how physicians can fulfill core measures. So long as physicians are able to fulfill menu measures where they fit into a menu measure’s applicable exclusion, psychiatrists will be able to fulfill the 3 of 5 menu measures CMS is mandating.

If however the language of the proposed rule, which states, “An EP must meet the criteria or an exclusion for all of the core objectives and the criteria for 3 of 5 menu objectives,” is interpreted by CMS to mean that a physician cannot fulfill menu measures for which he/she cannot meet the menu measures’ objective criteria by way of the measures’ specified exclusions, psychiatrists will be unable to fulfill more than one menu measure, thus rendering them unable to be Stage 2 meaningful users. This would be a change from Stage 1 policy that permitted an EP to reduce by
the number of exclusions applicable to the EP the number of menu set objectives the EP would need to meet. Psychiatrists must be permitted to satisfy 3 of these 5 current “menu” measures through exclusions. The rule should be rewritten to clarify CMS’ policy.

Payment Adjustment “Backdating”
The AACAP, with other physician groups, strongly opposes the back-dating of payment adjustments for physicians participating in the Stage 2 program. By statute, Medicare payment adjustments are required to take effect in 2015. In the proposed rule, CMS has proposed to back-date the reporting requirements under the Stage 2 program so that a physician will face a penalty based on activity undertaken in a year prior to the year of the penalty specified in the law. For example, although the law requires that penalties under Stage 2 of the Medicare/Medicaid meaningful use EHRIP begin in 2015, CMS is proposing to back-date the penalty program so that physicians who do not successfully meet meaningful use requirements in 2013 or by October 3, 2014, would face a penalty starting on January 1, 2015. CMS has pushed up deadlines for participation by a full year or more. This back-dating of payment adjustments will subject numerous physicians to financial penalties and slow down EHR adoption and implementation.

Exceptions to Meaningful Use Participation
While our members commend the benefits arising from greater physician EHR use, we urge CMS to exercise flexibility in its design of exceptions to physicians’ meaningful use participation. The proposed rule outlines three categories of exceptions that currently apply to our members. These include exceptions based on the lack of availability of internet access, barriers to obtaining IT infrastructure, a time-limited exception for newly practicing EPs who would not otherwise be able to avoid payment adjustments, and unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis. While the use of EHR is in its infancy, new circumstances may arise which necessitate the creation of an additional participation exception for physicians to claim.

For example, AACAP supports an exemption for physicians who are currently eligible for Social Security benefits or will be eligible for Social Security benefits by 2014. It would be economically burdensome for physicians who intend to retire in the next several years to purchase, install, and meaningfully use an EHR. We are also concerned that many of these physicians may decide to close their Medicare fee-for-service panels or opt out of Medicare to avoid penalties during the end stage of their clinical careers, which would adversely affect access to care for our nation’s elderly and disabled. Physicians who are currently eligible for Social Security retirement benefits or will be eligible for Social Security retirement benefits by 2014 should have the opportunity to apply for an exemption from the meaningful use program penalties.

Modifications to Medicaid EHR Incentive Program
AACAP endorses CMS’s proposal to expand the definition of what constitutes a Medicaid patient encounter so that it encompasses Title XXI-funded Medicaid expansion encounters. Additionally, we support CMS’s proposal to make approximately 12 additional children’s hospitals, which have not yet participated to date due to lack of a CMS certification number, eligible for the Medicaid EHRIP.
Stage 2 Timeline Delay
AACAP strongly supports CMS's proposal to delay the implementation of the onset of Stage 2 MU criteria until 2014. In its Stage 1 rule, CMS established that any provider who first attested to Stage 1 criteria for Medicare in 2011 would begin using Stage 2 criteria in 2013. CMS's proposal to push the use of Stage 2 criteria back one year may help child and adolescent psychiatrists seeking to become meaningful users, in addition to assisting the vendors who need additional time to develop Certified EHR Technology. We believe that the timelines for becoming a meaningful user are too accelerated as presently set.

Proposed Clinical Quality Measures (CQMs) for EPs Beginning with CY2014
In AACAP's previous comments on meaningful use, we expressed concern that there were few clinical quality measures applicable to child and adolescent psychiatric practices. AACAP commends CMS for adding several CQMs to the Stage 2 program that are directly applicable to the practice of child and adolescent psychiatry. These measures include: NQF #004, NQF #106, NQF #107, NQF #0108, NQF #0110, NQF #0418, NQF #0419, and NQF #1365. However, there is still a dearth of measures for both children and mental health, two areas targeted in numerous government agencies' policies and reports as topics for quality improvement focus and needed research. Although measures exist for children with ADHD and depression, there is an opportunity to develop measures focusing on overall outcomes of children, and adults, with mental health disorders, as well as other outcomes that will affect overall population health, such as obesity in children on certain medications. AACAP calls on CMS and other organizations to promote the research and development of measures in these areas.

CMS proposes two reporting options that would begin in CY2014 for physicians trying to fulfill Stage 2 CQM measure reporting requirements. Under Option 1(a), EPs would be required to report 12 CQMs from those listed in Table 8 of the Stage 2 proposed MU rule, including at least one measure from each of the six domains (Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, and Clinical Process/Effectiveness). Under Option 1(b), EPs would be required to report 11 “core” CQMs listed in Table 6 of the proposed Stage 2 MU rule, plus one “menu” CQM from Table 8. AACAP believes there are a limited number of CQMs routinely available for child and adolescent psychiatrists to fulfill under either Options 1(a) or 1(b). We believe our members will have a particularly difficult time trying to satisfy one measure from each of the six specified domains, as required by Option 1(a). Most of the measures that are routinely relevant to the practice of psychiatry fall under only three domains (Clinical Process/Effectiveness, Population/Public Health, and Patient Safety). We urge CMS to consider a third option: physicians would report six CQMs, including at least two clinically relevant measures from any (not each) of the six domains. This would be a much more feasible option that would help ensure child and adolescent psychiatrists can identify measures relevant to their specialty.

Conclusion
AACAP appreciates the efforts CMS has undertaken to make the EHRIP more relevant to specialists and commends CMS for devising exclusions to the core and menu measures that are broad enough to include psychiatrists. If CMS were to implement proposed Stage 2 meaningful use menu measures without allowing physicians who cannot meet the menu measures' objective criteria, to complete performance of the measure via applicable exclusion criteria, it is highly
questionable as to whether any child and adolescent psychiatrist would be able to fulfill 3 of 5 menu measures and consequently qualify for a Stage 2 incentive payment.

Physicians who treat patients suffering from mental illness and particularly children and adolescents stand to benefit from CMS’s efforts to include more CQMs that are relevant to the treatment of mental health in children within the EHRIP. For EHRs to succeed at improving patients’ care and health outcomes while reducing overall health care costs, EHR measures must be of utility to physicians treating patients who suffer from mental illness. CMS has stated that it selects CQMs looking at conditions that contribute the most to Medicare and Medicaid beneficiaries’ morbidity and mortality as well as conditions that are common to health disparities. This reasoning for measure inclusion is in itself an argument for the inclusion of more CQMs of relevance to mental health treatment. Persons with mental illness have on average 25 fewer years of life expectancy than persons not suffering from mental illness.

Additionally, before CMS issues a Stage 2 meaningful use Final Rule, AACAP and other physician groups urges CMS to review Stage 1 MU EP results to better understand the plausibility of elevating the percentage thresholds of numerous core measures. If a good percentage of EPs have not satisfied the percentage thresholds set for Stage 1 core measures, it is unlikely they will be able to satisfy much higher thresholds which have been proposed in this rule for Stage 2 core measures.

Much of the legislative intent of health reform has been to facilitate physicians’ ability to deliver more efficient, cost-effective, and coordinated care to Medicare beneficiaries. Much of the result has been an avalanche of quality measure programs with varying start dates, reporting requirements, and financial incentives and penalties being imposed upon Medicare beneficiaries’ physicians over a short time period. AACAP fears that as a result of weighty administrative burdens arising from the ACA-created quality measure reporting programs like PQRS, eRx, and EHRIP, members may choose to no longer see Medicare/Medicaid beneficiaries. With a growing shortage of child and adolescent psychiatrists currently limiting access to care for all American children and adolescents, we cannot afford to further restrict Medicare/Medicaid beneficiaries’ access to care. CMS should seek to implement quality measures that promote quality coordinated patient care while not making it unduly burdensome for physicians to treat Medicare patients.

Thank you for the opportunity to comment. If you have any questions, please contact Kristin Kroeger Ptakowski, Senior Deputy Executive Director; Director of Government Affairs and Clinical Practice at kkroeger@aacap.org, 202-966-7300, ext. 108.

Sincerely,

Martin J. Drell, M.D.
President