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January 28, 2016

The Hon. Lamar Alexander
Chairman
Health, Education, Labor and Pensions Committee
U.S. Senate
Washington, D.C. 20510

The Hon. Patty Murray
Ranking Member
Health, Education, Labor & Pensions Committee
U.S. Senate
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray,

On behalf of the American Society of Cataract and Refractive Surgery (ASCRS), a medical specialty society representing nearly 9,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care, thank you for this opportunity to provide comments on the staff draft for bipartisan legislation to improve health information technology for patients and families.

ASCRS offers specific comments on the following provisions:

Section 2. Assisting Doctors and Hospitals in Improving the Quality of Care for Patients

ASCRS supports and appreciates the Committee's efforts to reduce the regulatory burden the EHR Meaningful Use program places on physicians and other providers. Establishing a goal and implementing a strategy for reducing regulatory and administrative burdens, such as documentation requirements, is a good first step in improving physicians' experiences. However, ASCRS encourages the Committee to provide more relief to physicians and practices currently struggling to meet unachievable thresholds and measures that are not relevant to their specialty practices. Specifically, the Committee should provide additional guidelines and goals to CMS that will ensure an easing of regulatory burdens for physicians and practices.

While we understand CMS plans to overhaul the Meaningful Use program, we still have concerns that the agency does not fully understand the burden this program has placed on specialty providers. As the Committee develops its proposals regarding the Meaningful Use program, it should consider the following goals to be included in a strategy for reducing burden on physicians:

- Reduce measure thresholds to more achievable levels;
• Eliminate measures that hold physicians responsible for the actions of patients and other physicians, which are out of their control;
• Develop meaningful and achievable measures for specialty practices, rather than relying mostly on primary care measures;

- Remove the current “all-or-nothing” approach to Meaningful Use and instead allow for partial credit for attestation;
- Focus on interoperability of certified EHR Technology (CEHRT); and
- Continue to provide for flexibility and expanded eligibility for hardship exemptions beyond what is already enacted for 2015.

Prior to the release of the Stage 2 Modifications rule, many ophthalmologists had difficulty meeting the thresholds for certain measures, such as using electronic prescribing; using computerized provider order entry to enter medication; laboratory and diagnostic imaging orders, and using the EHR to send secure electronic messages to patients. In particular the measure requiring 5% of patients to view, download, or transmit their health information was difficult for our members to meet since ophthalmologists treat a relatively high number of Medicare patients who may not have the ability or inclination to take the required action. Physicians have no control over whether patients access this information and many ophthalmologists will fall short of the threshold. Under Stage 3, and likely going forward into MIPS, CMS has increased the thresholds for all of these measures.

In addition, the measures themselves are not related to the care they are providing and are time-consuming to measure. For example, measures such as computerized provider order entry for laboratory or radiology reports, and medication reconciliation are not typically relevant to ophthalmology. Beyond just focusing on reducing provider documentation, the Committee should set goals for what should be measured. The Committee should require CMS to accept measures developed by individual medical specialty organizations to focus on providing meaningful measures for specialty providers and ensuring that all required measures are within a provider’s control. Finally, the “all-or-nothing” approach for Meaningful Use means physicians who may only slightly fall short on even one measure are penalized. ASCRS feels strongly that if providers are attesting for Meaningful Use and meet a certain percentage of the measures, there should be an option for them to get credit for the percentage of Meaningful Use requirements they were able to successfully complete.

Section 3. Transparent Ratings on Usability and Security to Transform Information Technology

ASCRS supports the Committee’s efforts to increase transparency and provide physicians with a reliable method for evaluating and selecting CEHRT. In addition, we appreciate the Committee’s efforts to provide hardship exemptions for physicians who are unable to attest due to a de-certified EHR. We would caution the Committee, however, in assessing penalties and fees that are too high, since Health IT vendors would likely pass those costs on to their customers—in this case, physicians.

Section 4. Information Blocking

ASCRS supports efforts to reduce health information blocking as a key factor in encouraging EHR interoperability. Healthcare providers should only be penalized for information blocking if they act in a knowing and unreasonable manner to restrict the flow of health information.

Section 5. Interoperability

ASCRS supports efforts to encourage and increase EHR interoperability. ASCRS believes there are significant interoperability issues in the current Meaningful Use program. EHR vendors are not sharing data with each other, and are also not sharing data with registries. There are also well-documented issues with problems between vendors for measures, such as sharing summaries of care. CMS should be required to focus on increasing the functional interoperability between vendors and among vendors and registries to ensure Meaningful Use is a program that actually has the potential to improve healthcare.

We appreciate the Committee's efforts to engage the stakeholders in an agreement, but believe there should be more precise standards to ensure the seamless exchange of health information between EHR systems, settings of care, and data collection tools, such as between EHRs and registries. We believe the Committee should require EHR vendors to provide clinical data in a standard format that is backed by standardized data definitions, instead of physicians incurring the cost of developing additional software to map and transmit data. Finally, if the Committee seeks to reduce the regulatory burden on providers, the Meaningful Use program must be re-tooled to focus less on the process of data collection.

Health Information Technology Advisory Committee

ASCRS supports the creation of the Health Information Technology (HIT) Advisory Committee and appreciates that among its several policy duties is to consider the current quality reporting programs including Meaningful Use, PQRS, and the VBPM, as well as the development of the MIPS. ASCRS believes that by the time this committee is instituted, however, CMS will be well into its plans for implementing MIPS and so the advisory committee may not have an opportunity to make a meaningful impact. Instead, ASCRS recommends the HIT Advisory Committee also be tasked with studying and developing recommendations regarding reducing the regulatory and administrative burden on physicians and other providers subject to these programs.

Section 6. Leveraging Health Information Technology to Improve Patient Care

ASCRS supports efforts to require CEHRT to transmit, receive, and accept data from clinical data registries, including clinician-led clinical registries and that registries be required to transmit and receive data from CHERT.

Section 7. Empowering Patients and Improving Patient Access to Their Electronic Health Information

ASCRS supports efforts to increase patient access to electronic health information, and is pleased to see provisions in this draft requiring the Office of the National Coordinator to educate patients and promote the use of electronic health information. ASCRS cautions the Committee, however, against relying too heavily on patient engagement to provide and update information. As mentioned above, ASCRS members, who treat a disproportionate share of elderly Medicare beneficiaries who may have limited access to or interest in technology, have consistently struggled to meet patient engagement measures under the Meaningful Use program. Physicians should be encouraged to offer these tools to their patients, but not be penalized if the patients choose not to use them.

In addition to patient engagement measures, physicians currently struggle to meet measures requiring transitions of care to other providers who may not be equipped to receive them. Specifically, one measure included in Stage 3 Meaningful Use requires that for more than 50 percent of transitions of care and referrals, the eligible professional creates a summary of care and electronically exchanges the summary of care record. While CMS has clarified with ASCRS that providers can meet this measure for Stage 2 by sending an email, many EHR systems are only able to meet this measure by exchanging information with other providers who have an EHR system that will accept a Consolidated-Clinical Document Architecture (C-CDA) formatted document. This is problematic as many of our providers are located in areas where the doctors they refer patients to and receive patients from do not have an EHR. Therefore, our providers are often penalized for the decision of surrounding providers not to adopt EHR systems.

Overall, providers who are attempting to attest to Meaningful Use should not be penalized for actions they cannot control. We have repeatedly commented to CMS that measures like these are particularly difficult for specialists to meet. CMS continues to develop measures that physicians have no control over, and we believe there are ways to ensure interoperability without relying on other providers or patients to complete specific actions. The Committee should require CMS to ensure that each measure required for Meaningful Use is one that providers are able to attest to without relying on the actions of other individuals (patients or referring providers).

ASCRS appreciates this opportunity to provide input to the Committee's health information technology draft and believes it represents a good starting point for improving physician and patient access to EHR. We encourage the committee to expand its provisions relating to reducing regulatory burden on physicians and provide true reforms to the Meaningful Use program.

For additional information, please contact Nancey McCann, Director of Government Relations, at nmccann@ascrs.org or 703-591-2220.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Cionni', with a long horizontal flourish extending to the right.

Robert J. Cionni, MD
ASCRS President