May 26, 2015

The Honorable Andy Slavitt,
Acting Administrator,
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3311-P

Submitted electronically at http://regulations.gov

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Modifications to Meaningful Use in 2015 through 2017

Dear Mr. Slavitt:

The College of Healthcare Information Management Executives (CHIME) appreciates the opportunity to submit comments regarding the Notice of Proposed Rulemaking (NPRM) outlining modifications to the Electronic Health Record (EHR) Incentive Program for years 2015 – 2017 published in the April 15, 2015 edition of the *Federal Register*.

CHIME has more than 1,400 members, composed of chief information officers (CIOs) and other top information technology executives at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business information technology (IT) systems that will facilitate healthcare transformation. We share the vision of an e-enabled healthcare system as described by the many efforts under way at the Department of Health and Human Services.

Before offering recommendations on specific proposals, we wish to highlight a few general comments.

CHIME wishes to express our thanks to CMS for making a series of successive changes to the EHR Incentive Program over the last twelve months, culminating in the release of this NPRM. In combination, these changes will greatly improve the ability of eligible professionals (EPs) eligible hospitals (EHs) and critical access hospitals (CAHs) to successfully participate in the program, thus

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enabling broad adoption and improved use of health IT towards achievement of the triple aim of better care, improved health and lower costs.

Specifically, CHIME enthusiastically supports the proposed shortened EHR reporting period of any continuous 90-day period in 2015. The additional time afforded by this modification will help hundreds of thousands of providers meet meaningful use (MU) requirements in an effective and safe manner. Further, it will serve as positive incentive for those who optioned alternative pathways to meet MU in 2014 to continue their work in 2015 and beyond. A shortened reporting period will enable them to participate in MU successfully during the 2015 reporting period.

Further, we support the proposed modifications for Patient Electronic Access, Secure Messaging & Summary of Care objectives. **CHIME continues to reject any requirements that place accountability for patient behavior beyond what a clinician or healthcare provider institution can control, and we believe the proposals eliminating percentage thresholds for patient actions outlined in this NPRM adequately address our concern.** However, we wish to reiterate to policymakers that future efforts to build on this flawed approach to patient engagement will continue to be met by resistance from providers, and it will deflect focus on how to foster true patient engagement. This is because the patient action requirement has taken care providers away from patients and reassigned them to the role of email collectors; it has created an array of information silos for patients to aggregate and new passwords for patients to remember; and new research indicates the proliferation of portals could lead to greater health disparities[1]. As our industry continues the discussion of how best to engage the patient through technology, and how best to measure these efforts, we encourage CMS to think more innovatively around the concept of patient engagement, how to differentiate between those that do it well and those who do not, and how to incentivize laggards.

Despite our general support for this NPRM, CHIME is concerned with two specific proposals. Specifically, we do not support the proposed exclusion pathways associated with the public health objective and the requirement for bi-directional exchange for immunizations registries because we believe these requirements go beyond what current Stage 2 requires. We do not disagree with the need to develop towards bi-directional functionality, but our members indicate that it simply is not feasible for most products at this time. We also are concerned that proposed changes to the attestation deadline will prohibit providers from attesting before the end of CY 2015, even though they may be eligible or ready to do so. We ask CMS to revisit proposals related to the public health objective and we identify specific recommendations later in these comments. Likewise, we recommend that CMS allow providers who are eligible and willing to attest before January 2016 the option to do so.

[1] S. G. Smith, R. O'Conor, W. Aitken, L. M. Curtis, M. S. Wolf, M. S. Goel. **Disparities in registration and use of an online patient portal among older adults: findings from the LitCog cohort**. *Journal of the American Medical Informatics Association*, 2015; DOI: 10.1093/jamia/ocv025

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Finally, some members have expressed concern over the timing of this NPRM. Given recent experience, we know that certified EHR technology is not homogenous and is not implemented consistently across settings. While we are sure that some products will need very little, if any, software rewrites to accommodate these proposed modifications, we are equally sure that some products will need some level of rework. Given this, we ask CMS to provision hardship exceptions for providers who do not have time or resources to comply with these proposed changes, especially given the expected timing of a final rule relative to the final 90-day reporting period in program year 2015.

More detailed recommendations and rationale are offered in the attached document to address questions posed by CMS. We urge officials to contact Leslie Krigstein, Interim Vice President of Public Policy, at lkrigstein@chimecentral.org or (202) 507-6158, with any questions, comments or concerns.

We look forward to a continuing dialogue with your office on how to improve the likelihood of success for the EHR Incentive Program and to build on the foundation this program is providing for continued healthcare transformation.

Sincerely,

Russell P. Branzell, CHCIO, LCHIME
President and CEO
CHIME

Charles E. Christian, CHCIO, LCHIME, FCHIME, FHIMSS
Chair, CHIME Board of Trustees
Vice President of Technology & Engagement
Indiana Health Information Exchange

CC: Dr. Karen DeSalvo, National Coordinator, Office of the National Coordinator for Health Information Technology, US Department of Health & Human Services

Enclosed Attachment

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Section II.A.1. Meaningful Use Requirements for EHR Reporting Periods in 2015 – 2017
CMS proposes to modify existing Stage 2 requirements, with accommodations for Stage 1 providers, in EHR Reporting Periods 2015 through 2017. Among these modifications are proposals to:

1. Change the definition of "EHR reporting period" for EPs and EHs / CAHs such that it aligns with a calendar year;
2. Allow a 90-day reporting period (2015 only);
3. No longer require providers attest to a number of redundant, duplicative, or topped out measures;
4. Eliminate the distinction between core and menu objectives; and
5. Mandate full-year reporting of Stage 2 modified measures beginning in CY 2016 for all providers (with exclusions and alternative measures available for those scheduled to meet Stage 1 requirements);

CHIME is generally supportive of the changes outlined in section II.A of the proposed rule. We believe this kind of reorientation will give providers much needed experience in a new MU paradigm before meeting the more challenging Stage 3 requirements.

RECOMMENDATION: CHIME supports the reporting period shift from a fiscal to a calendar year for all providers. However, we recommend CMS allow providers who are able to attest to MU in 2015 before January 1, 2016 the option to do so. While we support the proposal to move all providers to a calendar year to simplify attestation and compliance requirements, we are concerned such a shift in 2015 will cause some providers financial hardships if they had expected to have incentive cash on-hand to remain operational. We discuss rationale for this further in section II.C of our response.

CMS also sought comment on a proposal to allow first-time participants to the program in 2016 to demonstrate meaningful use during any continuous 90-day period during the calendar year, and requiring all returning participants to report over a full calendar year. In 2017, CMS proposed the EHR reporting period would be one full calendar year for all providers, regardless of historic participation, as proposed in the Stage 3 proposed rule (80 FR 16739).

RECOMMENDATION: CHIME recommends CMS finalize their proposed EHR reporting period for 2016 and amend its proposal for the 2017 EHR reporting period. We support the proposal allowing first-time providers the ability to attest with any continuous 90-day EHR reporting period in calendar year 2016. However, we do not support the notion that every provider, regardless of previous experience, be expected to attest over a full calendar year in 2017. We recommend CMS give late entrants to the EHR Incentive program the same first-year accommodations as early adopters. By giving providers the option of a shortened EHR reporting period they will have more incentive to begin their journey than would otherwise be the case. And consistent with similar recommendations, CHIME asks CMS to allow all providers the option of a

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90-day reporting period during the first year of any new Stage. In this case, it would apply to either 2017 or 2018, depending on when the provider chose to attest to Stage 3 objectives.

CMS sought comment on their proposal to no longer require providers to attest to objectives and measures currently codified in the CFR under § 495.6 in order to demonstrate meaningful use beginning in 2015. The objectives and measures listed under § 495.6 are those measures and objectives CMS believes are either "redundant, duplicative, or topped out with new participants consistently performing at a statistically comparable rate to returning participants."

RECOMMENDATION: CHIME supports the removal of these so-called "topped out" measures.

CMS sought comment on whether or not it should implement only the modifications proposed in this rule from 2015 through 2017 and begin Stage 3 in 2018, or if it should allow providers the option to demonstrate Stage 3 in 2017.

RECOMMENDATION: CHIME recommends CMS finalize proposals that allow for provider flexibility, including the option to attest to Stage 3 in 2017 should the provider want this option. This will enable providers who wish to be among the vanguard the option to do so, while generating much-needed experience with Stage 3 measures for other providers.

Section II.A.2. Meaningful Use Objectives and Measures for 2015, 2016, and 2017

CHIME recommendations related to the proposed objectives and measures can be found in Table 1, beginning on page 7 of this document. We again highlight our firm support for many of these proposed objectives and measures contingent upon CMS accepting recommended changes to the public health objective exclusions policy and an optional shift to a calendar year reporting period for hospitals in 2015.

The proposed rule expands public health to 6 possible measures and requires a provider to exhaust all possible options before being eligible for an exclusion in 2015. The proposed rule, as currently written, creates a true hardship for many of our members who will have to find and initiate a new public health reporting measure project for the current reporting period. The prevalence of exclusions in public health is well documented in the ONC Data Brief No. 22 which reports that "one in five stage 2 hospitals could not meet the [syndromic surveillance] measure because the local public health agency could not accept the data" and "fifteen percent of stage 2 hospitals could not

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electronically submit laboratory results because the local jurisdiction could not accept them" in fiscal year 2014.[2]

RECOMMENDATION: CHIME recommends the final rule be written to allow providers to utilize an existing exclusion in 2015, as already planned. In the parlance of the *NPRM – Modifications to MU for 2015-2017*, this could be included as an "alternate exclusion" for public health. Our request is consistent with the language described at FR 80 20356 in which CMS is "proposing to establish ***alternate exclusions*** and specifications to mitigate any additional burden on providers for an EHR reporting period in 2015." We recommend the same consideration for providers needing to meet the public health measures in 2015.

Additionally, we understand public health objective, Measure Option 1 - Immunization Registry Reporting will require bi-directional interface capabilities. This is a concern because such capabilities are not currently available in most certified EHR vendor systems, and the bi-directional functionality was not required in the 2014 Edition certification criteria for public health reporting.

RECOMMENDATION: CHIME asks that the final rule specify that bi-directional messaging be postponed to MU Stage 3, after vendors upgrade to the 2015 Edition certification criteria. We do not disagree with the need to develop towards bi-directional functionality, but our members indicate that it simply is not feasible for most products at this time. Further, we oppose any notion that bi-directional functionality be required "if the vendor has the capability" as that penalizes those progressive vendors who are moving out front of regulation, as well as their provider partners.

[2] Heisey-Grove, Chaput, Daniel, "Hospital Reporting on Meaningful Use Public Health Measures in 2014," ONC Data Brief 22, March 2015 http://bit.ly/1QTv6DX

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Table 1: CHIME Comments on Proposed EHR Incentive Program Objectives & Measures, 2015 – 2017

Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
CPOE	**Measure 1:** More than 60% of medication orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. **Measure 2:** More than 30% of laboratory orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. **Measure 3:** More than 30% of radiology orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: **Alternate Measure 1:** More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30 percent of medication orders created by the EP during the EHR reporting period, or created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry. **Alternate Exclusion for Measure 2:** Provider may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015 since there is no equivalent Stage 1 measure. **Alternate Exclusion for Measure 3:** Provider may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting	CHIME believes the proposed alternate Measure and Measure exclusions are appropriate and support the continued inclusion of CPOE as a required objective. It has been the experience of our members that MU has driven widespread use of CPOE to a degree that many CIOs and CMIOs had historically struggled to achieve. We recommend that CMS consider harmonizing Measure 3 in future years to align with how Stage 3 measures radiology/diagnostic orders, should it finalize the proposed Stage 3 Measure.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
	recorded using computerized provider order entry.	period in 2015 since there is no equivalent Stage 1 measure.	
eRx	EP Measure: More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using Certified EHR Technology. Eligible Hospital/CAH Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: Alternate EP Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using Certified EHR Technology. Alternate EH Exclusion: Measure Exclusion: Provider may claim an exclusion for the eRx objective and measure if for an EHR reporting period in 2015 they were either scheduled to demonstrate Stage 1, which does not have an equivalent measure, or if they are scheduled to demonstrate Stage 2, but did not intend to select the Stage 2 eRx menu objective for an EHR reporting period in 2015.	CHIME recommends CMS make this an optional requirement for EHs in 2015 and 2016. We are concerned that hospitals who are eligible for the stated exclusion will have a difficult time defending this decision in an audit. Further, we believe that hospitals who did not intend to implement eRx in their environment will need more than a few months to be ready for a full-year reporting.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
Clinical Decision Support	**Measure 1:** Implement five CDS interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. **Measure 2:** The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. **Exclusion:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: **Alternate Measure 1:** Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule. **Measure 2 Alternate:** EP, EH or CAH who is scheduled to participate in Stage 1 in 2015 must also satisfy the Stage 2 measure 2 because it is the same as the existing Stage 1 measure.	CHIME supports this proposed change.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
Patient Electronic Access (VDT)	EP Measure 1: More than 50 percent 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. EP Measure 2: At least one patient seen by the EP during the EHR reporting period (or their authorized representatives) views, downloads, or transmits his or her health information to a third party. Eligible Hospital/CAH Measure 1: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.	**Alternate Exclusion Measure 2:** Provider may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.	CHIME overwhelmingly supports this proposal, and we reiterate our opposition to requirements that place accountability on providers for things they cannot control.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
	Eligible Hospital/CAH Measure 2: At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or his or her authorized representative) views, downloads, or transmits to a third party his or her information during the EHR reporting period.		
Protect ePHI	**Measure:** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process.	**NONE**	CHIME supports the continued inclusion of Protect ePHI as a required objective.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
Patient Specific EDU	EP Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period. Eligible Hospital/CAH Measure: More than 10 percent of all unique patients admitted to the eligible EH's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient specific education resources identified by Certified EHR Technology.	**Alternate Exclusion:** Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.	CHIME believes the proposed Measure exclusion for EPs and EHs is appropriate, and we support the continued inclusion of Patient Specific Education Resources as a required objective.
Medication Reconciliation	**Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	**Alternate Exclusion:** Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective	CHIME believes the proposed Measure exclusion for EPs and EHs is appropriate, and we support the continued inclusion of Medication Reconciliation as a required Objective.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
Summary of Care	**Measure:** The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	**Alternate Exclusion:** Provider may claim an exclusion for Measure 2 of the Stage 2 Summary of Care objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure	CHIME applauds CMS for this proposed change. Simplifying the objective by updating this measure to state "that a provider would be required to create the summary of care record using CEHRT and transmit the summary of care record electronically" without regard to how it is electronically transmitted is a genuinely positive alteration that will help build on work performed to-date without repeating past complications. Many members reported difficulty with establishing connections to meet the second threshold of 10 percent; however, we believe that an exchange ecosystem has developed to a degree where exchange pathways are now more usable – expanding allowable transport protocols will only help develop this ecosystem further. We support the inclusion of the Summary of Care as a required objective.
Secure Messaging	Measure: During the EHR reporting period, the capability for patients to send and receive a secure electronic message with the provider was fully enabled.	Alternate Exclusion: An EP may claim an exclusion for the measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.	CHIME supports and applaud the change to this objective. We believe the proposed Measure exclusion for EPs is appropriate, and we support the continued inclusion of Secure Messaging as a required objective for EPs. We note, however, that secure messaging is not considered relevant for most patients discharged from the inpatient or emergency department settings. Therefore, we

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			do not support this measure's inclusion in future requirements for EHs / CAHs.
Public Health	Objective: EPs would be required to choose two from measures 1 through 5 and successfully attest to any combination of two measures. EHs / CAHs would be required to choose three from measures 1 through 6 and successfully attest to any combination of three measures. **For both EPs and EHs / CAHs, measures 4 and 5 may be counted more than once, if more than one Public Health Registry or CDR is available, and thereby count toward accomplishment of 2 (EPs) or 3 (EHs / CAHs) that must be satisfied.** **Measure Option 1** - Immunization Registry Reporting: The EP, eligible hospital, or CAH is in active	**NO Alternates or Exclusions specific to 2015 only** CMS proposes that an exclusion for a measure would not count toward the total of 2 or 3 measures that must be met by an EP or hospital, respectively. For example, if an EP qualifies for an exclusion, the EP would still need to meet two of the total number of measures available to them. However, if the EP qualifies for multiple exclusions and the remaining number of available measures is less than two, the EP could meet the objective by meeting the remaining measure (if any). **Measure 1:** The EP or hospital does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the EHR reporting period.	CHIME has concerns related to this objective. Conceptually, we believe CMS is making a rational decision to combine public health reporting measures and giving providers options to meet a subset of the total. However, we are concerned the NPRM creates too stringent an exclusion policy for providers. This will likely require thousands of EPs and EHs to reorient their engagement with outside parties to successfully meet this measure, which will likely require time, money and technical resources. We do not believe this would be a misguided effort, but are concerned that many providers put in the position to reconfigure how they meet this objective will take more time than what is expected, were providers required to meet this requirement in 2015.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
	engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). **Measure Option 2** – Syndromic Surveillance Reporting: The EP, eligible hospital/, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs, or an emergency or urgent care department for eligible hospitals and CAHs (POS 23). **Measure Option 3** - Case Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions.	Measure 2 (EPs): The EP does not treat or diagnose or directly treat1 any disease or condition associated with a syndromic surveillance system in their jurisdiction. Measure 2 (Hospitals): The hospital does not have an emergency or urgent care department. **Measure 3:** The EP or hospital does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period. **Measure 4:** The EP or hospital does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period. **Measure 5:** The EP or hospital does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period. **Measure 6:** The hospital does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period.	For these reasons, CHIME strongly recommends this measure be excluded from 2015 requirements, but rather take effect in 2016. In the meantime, CMS should maintain the current public health reporting options and exclusions. Alternatively, were CMS to supply guidance and / or affirm through finalization of this rule that "prior action" of securing an exclusion in 2015 can be counted as one of the three measures for an eligible hospital (or two measures for an EP), we could support its inclusion in the 2015 required objectives set. Again, we do not disagree with the approach, but we also do not believe it will be easily implemented with such little time between finalization and the beginning of the last 90-day reporting period – October 1, 2015. Relative to individual measure options, our members have expressed doubt as to the ability of immunization registries to comply with a bi-direction exchange of information until the new Edition of certified health information technology is widely available.

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Proposed Objectives	Proposed Measures 2015-2017	Proposed Alternate Measures, Exclusions (2015 ONLY)	CHIME Comments
	Measure Option 4 - Public Health Registry Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit data to public health registries. **Measure Option 5** – Clinical Data Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry. **Measure Option 6** – Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.		

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Section II.A.3 Certified EHR Technology

CMS proposes no further changes to the definition of CEHRT in this proposed rule and they reiterate that providers must use EHR technology certified to the 2014 Edition for an EHR reporting period in 2015.

RECOMMENDATION: CHIME agrees with this approach.

Section II.A.4 Medicaid EHR Incentive Program in 2015 through 2017

CMS proposes to provide an alternate attestation option for Medicaid providers who are seeking to demonstrate meaningful use to avoid the Medicare payment adjustment and who are prohibited from switching between the Medicare and Medicaid EHR incentive programs. This option is intended for providers who participate in the Medicaid EHR Incentive Program but due to patient volume or other factors are unable to attest to meaningful use through their state Medicaid program for a given year.

Under this proposed option, providers could use the Medicare Registration and Attestation System to attest to meaningful use without switching programs (but solely for the purpose of avoiding the Medicare payment adjustment).

RECOMMENDATION: CHIME agrees with this approach.

In Section II.C. CMS says that under this proposed rule, Medicaid providers using the alternate attestation option in 2017 or subsequent years would also be required to use an EHR reporting period of 1 full calendar year even if they are demonstrating meaningful use for the first time.

CHIME is concerned that the circumstances through which providers would find themselves needed to attest using the Medicare Registration and Attestation System to avoid a payment adjustment, such as patient volume or other factors, are not confined to a point in time. These same circumstances are just as likely in 2017 and beyond as they are in 2015 or 2016. Further, we do not agree with the requirement to have new entrants report on a full-year EHR reporting period in their first year of participation.

RECOMMENDATION: CHIME recommends CMS apply the same options to Medicaid providers in 2017 and beyond as is afforded to Medicaid providers in 2015 and 2016.

Section II.B. Clinical Quality Measurement

CMS proposes to maintain the existing requirements established in earlier rulemaking for the reporting of CQMs, including requirements for 9 CQMs covering at least 3 National Quality Strategy (NQS) domains for EPs and 16 CQMs covering at least 3 NQS domains for hospitals.

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RECOMMENDATION: CHIME agrees with this approach.

CMS also proposes a 90-day reporting period for CQMs for all providers. CMS adds that it would be acceptable for a provider to use a continuous 90-day reporting period for CQMs even if it is different from their continuous 90-day EHR reporting period for the meaningful use objectives and measures if that provider is reporting via attestation.

RECOMMENDATION: CHIME agrees with and appreciates the flexibility demonstrated by this approach.

CMS says EPs seeking to participate in multiple programs with a single electronic submission, such as PQRS and MU, would be required to submit a full calendar year of CQM data using the 2014 electronic specifications for CQMs for a reporting period in 2015. Hospitals seeking to participate in multiple programs with a single electronic submission for a reporting period in 2015 would be required to submit 1 calendar quarter of data for 2015 from either Q1, Q2, or Q3.

RECOMMENDATION: CHIME agrees with this approach.

Section II.C. Demonstration of Meaningful Use for 2015 through 2017

CMS proposes to continue to use attestation as the method for demonstrating that a provider has met meaningful use objectives and measures. However, CMS proposes to change the attestation deadlines for hospitals as follows:

- For an EHR reporting period in 2015, a hospital must attest by February 29, 2016.
- For an EHR reporting period in 2016, a hospital must attest by February 28, 2017.

CMS notes that providers would not be able to attest to meaningful use for an EHR reporting period in 2015 prior to January 1, 2016, since CMS needs time to make necessary system changes.

CHIME is concerned with the proposed change to the attestation deadline. Specifically, we see two distinct problems with the prohibition of attestations before January 1, 2016 for the 2015 EHR reporting period:

1. Some hospital-based members have indicated that such a prohibition would cause them a cash flow issue and jeopardize their ability to continue service delivery; and
2. Some members are planning to demonstrate meaningful use for the first time before this rule is finalized.

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We understand that CMS is currently prohibiting providers from attesting, even though they are capable and eligible. We also question the legal standing of prohibiting providers who are eligible to attest before the end of the CY 2015 from doing so.

RECOMMENDATION: CHIME recommends CMS allow providers who are eligible to attest before the end of CY 2015 the option to do so. Further, we recommend CMS allow hospitals the ability to attest at any point following finalization of the rule, should they be eligible and choose to do so.

Section II.D. Payment Adjustments and Hardship Exceptions

In Section II.C CMS outlines how a later attestation deadline for 2015 (of February 29, 2016) for new participants in the EHR Incentive Programs will mean that such new participants may be subject to a payment adjustment on claims submitted prior to attestation. CMS notes that after successful attestation, the payment adjustment would be removed and any adjustments previously applied to claims in 2016 would be reprocessed and reconciled for the provider.

RECOMMENDATION: CHIME recommends CMS allow providers who are eligible to attest before the end of CY 2015 the option to do so. For reasons articulated previously, we do not agree with the proposal to have all EHs and EPs attest after January 1, 2015, regardless of historic participation. Rather, we reiterate recommendations that would give providers the option to attest before, or congruent with, the end of the fiscal year for 2015 only. We reiterate the numerous benefits of this approach, including staggered use of the Registration and Attestation system, foregone reconciliation of improperly levied payment adjustments, more time for system modifications and less burden on providers or their vendor partners.

CMS proposes no changes or additions to the existing payment adjustment hardship exceptions for EPs or hospitals.

RECOMMENDATION: CHIME recommends CMS create a new hardship category for providers switching vendors. We note the Secretary is authorized to grant hardship exemptions to providers, subject to annual renewal, to avoid a financial penalty if certain circumstances are met. While CMS has created a number of hardship categories, we recommend CMS adopt a hardship exception for providers switching EHR vendors, especially if CMS moves forward with full-year reporting periods in perpetuity. Our members express concern with their inability to transition to new products during any given 365-day period due to the overwhelming complexity of the task and the increasing thresholds of program participation. Many members recall an adoption cycle that last, at minimum, 8 to 14 months. For safety and competition concerns, CMS should adopt a new hardship for providers switching vendors.

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