September 6, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically at: www.regulations.gov

Re: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program; Proposed Rule

Dear Mr. Slavitt:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to comment on changes to the Meaningful Use program outlined in the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule published by the Centers for Medicare & Medicaid Services (CMS) in the July 14, 2016, issue of the *Federal Register*. CHIME has more than 1,900 members, composed of chief information officers (CIOs) and other senior 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 appreciate that CMS heeded calls from the hospital community to create a more reasonable path forward in the Meaningful Use program as we

approach the Stage 3 era. We strongly support the proposal for a 90-day reporting period in 2016. Since the start of the Meaningful Use program in 2009, CHIME members have invested billions of dollars of in IT infrastructure, clinical training, and security to adhere to a complex and ambitious regulatory environment. The new CMS proposal provides welcomed relief to hospitals at a time when many of our members are facing substantial upgrades which are both costly to deploy and complex to operationalize. Creating flexibility to achieve Stage 3 is crucial, especially as more and more hospitals participate in new models of care that rely heavily on robust technologies to support care coordination and better manage chronically ill across the continuum.

In the rule, CMS calls for a shorter reporting period, lower thresholds, and fewer measures. CHIME strongly supports this direction. Below we offer our top recommendations, followed by more detailed comments. In addition to the changes proposed by CMS, we recommend that the agency:

1. **Finalize the proposal for a 90-day reporting period for 2016 as quickly as possible and adopt a likeminded policy for future years as well;**
2. **Reconsider the full-year reporting for electronic clinical quality measures (eCQMs) for hospitals and adopt a quarter reporting period instead;**
3. **Align regulatory requirements for clinicians and hospitals in the Medicare and Medicaid programs as closely as possible in order to maximize the greatest degree of flexibility;**
4. **Develop education tools for providers to help them navigate different sets of rules (i.e. Merit-based Incentive Program (MIPS) and Medicare versus Medicaid);**
5. **Only require provider use of new technologies when:**
    a. **They have become widely available and their functionality has been proven to improve patient care (i.e. application programming interfaces (APIs) and patient-generated data (PGD)); and**
    b. **Assuming new technologies are found to be effective, do not require a full-year reporting for any new Meaningful Use measures in order to give both vendors and providers time to adapt to the new criteria.**
6. **Reduce thresholds for hospitals for ePrescribing; the timeframe upon which information must be made available to patients upon discharge; secure messaging; patient-generated data (PGD); and public health and clinical data registry reporting; and**
7. **Any mandates for using registries must be preceded by proven, common data standards that are broadly available in the EHRs and implemented by the registries.**

Reporting Period

CHIME enthusiastically supports CMS' proposal which calls for reducing the reporting period for those Medicare eligible hospitals (EHs) and Critical Access Hospitals (CAHs) returning to the Meaningful Use program, for 2016. We have long endorsed a 90-day reporting period and are grateful CMS listened to our recommendations. However, we continue to believe that a 90-day reporting period

must be put in place for every reporting year especially in light of the fact that the "all-or-nothing" construct of the program remains intact for hospitals and other non-MIPS eligible providers. **We recommend CMS adopt a 90-day reporting period for 2016 and beyond.**

New Requirements

Stage 3 contains a number of new requirements for providers that involve the use of functionalities not previously required and in some cases the technology to facilitate them is not yet widely available and / or has not yet been proven to improve outcomes or function safely such as PGD and APIs. **We thus recommend two steps CMS should consider taking. First, we believe CMS should only require provider use of new technologies when they have become widely available and their functionality has been proven to improve patient care. Second, assuming new technologies are found to be effective, we recommend that CMS avoid full-year reporting for any new Meaningful Use measures in order to give both vendors and providers time to adapt to the new criteria.**

eCQMs

CHIME recognizes that eCQMs are outside the scope of the OPPS rule and that CMS has already finalized their policies for 2017. However, we want to take this opportunity to urge CMS to reconsider the full -year reporting period they adopted under the Inpatient Prospective Payment System (IPPS) final rule. Our members are very concerned that this requirement, if not changed, will significantly diminish many hospitals' ability to meet the reporting requirements for 2017. As we have explained to CMS, the following challenges present significant hurdles for providers:

- Vendor readiness;
- Many CIOs are navigating complex upgrades to accommodate these and other changes combined;
- Several hospitals are facing back to back major upgrades (i.e. one needed for eCQM compliance followed by another one for upgrading to Version 2015 Certified EHR Technology (CEHRT); and
- Substantial clinical workflow and staff training with insufficient time to prepare.

We strongly urge CMS to redact the full-year reporting policy and instead require measures be submitted for a single quarter in 2017.

Navigating Different Meaningful Use Rules

In addition to a 90-day reporting period in 2016, our members applaud CMS for exploring ways to increase flexibilities for providers in meeting the Meaningful Use requirements and we support CMS' proposals for lowering thresholds, removing measures, and reducing reporting burdens on providers. That said, we have concerns that the numerous permutations or "flavors" of Meaningful Use could be hard for providers to keep track of. Depending on how CMS finalizes the Advancing Care Information (ACI) section of MIPS there are different ways to meet the Meaningful Use-like measures (i.e. Modified

Stage-2 like measures vs Meaningful Use-3 like measures). In the OPPS rule CMS has proposed three sets of changes including a set for: 1) Medicare EHs and CAHs using modified Stage 2 measures in 2017; 2) Medicare EHs and CAHs using MU-3 measures for 2017 as an option and mandatory in 2018; and 3) all EPs in 2018 and beyond and for Medicaid EHs and CAHs for 2018.

Even for the most sophisticated health system, the ability to navigate the appropriate set of rules for the appropriate provider could be incredibly confusing. Further, we are concerned that the thresholds for Stage 3 remain largely intact for Medicaid providers who typically have fewer resources and who serve our nation's most disadvantaged and vulnerable populations. If Medicare providers are struggling to keep pace with Meaningful Use, Medicaid providers could be experiencing even greater challenges. Finally, we are confused by CMS' use of the term "all professionals" for the third set of changes to the program proposed in this rule which begin in 2018. Since Meaningful Use sunsets for MIPS eligible professionals starting in 2018, we seek clarification from CMS on whether they meant to say "All professionals with the exception of MIPS eligible professionals."

Taking these concerns into account, we recommend CMS: 1) create an online decision tool and education materials to help providers best discern which set of Meaningful Use requirements apply to them; 2) adopt the same changes for Medicaid providers as they have proposed for Medicare providers; and 3) continue to align hospital and MIPS eligible professional Meaningful Use and Meaningful Use-like measures as closely as possible.

CHIME Comments on Specific Measures

A. ePrescribing

CMS proposed retaining the previously adopted threshold of more than 25% for Stage 3 for hospitals rather than reducing it. **CHIME continues to believe that this threshold is too high and recommends that it remain at 10%.** This measure is still extremely new for hospitals and we are concerned that raising the threshold to 25% is premature. Hospitals are still adapting to workflows and this a new mandate for most hospitals. Also, we continue to believe that including controlled substances should continue to be optional since provider and vendor readiness issues are still being addressed. The proposed rule is silent on this piece and while we presume CMS intends to retain the flexibility to include or exclude controlled substances depending on the provider's current situation, we nonetheless seek clarification on this point.

B. CDS & CPOE

Under both Modified Stage 2 in 2017 and Stage 3 in 2017 and 2018, CMS proposed eliminating the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures for EHs and CAHs attesting to Meaningful Use under Medicare. CMS is removing these measures because they have determined they are "topped out." The proposed changes would not apply to EHs and CAHs that attest to Meaningful Use under their state's Medicaid EHR Incentive Program.

However, CMS has proposed that the CEHRT capabilities a hospital has still must include CDS and CPOE. CIOs strongly support the use of CPOE and CDS as ways to help drive better care. However, since the Meaningful Use program's "pass / fail" construct remains in place, we believe removing these measures from the requirements that providers must meet makes sense. Therefore, **CHIME supports removal of both the CPOE and CDS measures.**

C. Patient Electronic Access to Health Information Objective

Hospitals are required to provide patients (or their representative) with timely electronic access to their health information and patient-specific education. CMS proposed changes to the thresholds to both measures under this objective.

First, CMS proposed reducing the measure which calls for patients to have access to view, download and transmit their information using any ap of the patient's choice facilitated by the provider's use of an API configured meet the technical specifications of the API in the provider's CEHRT. While we support the notion of reducing the threshold from more than 80% to more than 50% for the patients that must be given this access when discharged, we continue to have serious concerns with the requirement that this must be facilitated via an API. CHIME believes that use of APIs holds promise for helping access and contextualizing patient information. However, we reiterate that there is tremendous uncertainty regarding mandating the use of APIs, including potential security and authentication issues, and even whether they will be readily available in vendor products by 2018. **We continue to believe this mandate is premature and urge CMS to remove this piece from the measure.**

Second, while CMS specifically calls out 36 hours following patient discharge for when this information must be made available under Modified Stage 2, CMS does not indicate a specific time for Stage 3 for Medicare EHs and CAHs in this rule. For both Modified Stage 2 and Stage 3 CHIME continues to **recommend 72 hours as the appropriate timeframe because we believe this will give clinician adequate time to sign the note.**

Lastly, CMS proposed reducing the threshold from requiring hospitals use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials when patients are discharged from the hospital or emergency department from more than 35% of unique patients to more than 10% of patients. **CHIME supports CMS' proposal for a more than 10% threshold for Stage 3.**

D. Coordination of Care through Patient Engagement

CHIME strongly endorses the lower thresholds CMS proposed in meeting the measures that comprise the coordination of care through patient engagement objective. However, we continue to have significant concerns with several pieces of this objective which is comprised of three multi-faceted measures.

Under Stage 3, measure one requires providers to ensure that at least one patient discharged from the hospital or ED actively engages with the provider's CEHRT system by: 1) viewing, downloading or transmitting their information to a third party; 2) accessing their health information through the use of an API through patient-selected aps; or a combination of 1 and 2. **CHIME endorses CMS' proposal to reduce the threshold for this measure from 5% of patients in 2017 and from 10% in 2018, to at least one patient. However, we recommend removing the API portion of the mandate or making it optional, due to concerns articulated earlier.**

The second measure in this objective calls for hospitals to send secure messages to more than 5% of patients discharged from the hospital or ED. **CHIME appreciates that CMS has reduced this threshold from more than 25% to more than 5% and supports the ability of patients to communicate securely in an electronic manner with their clinicians. However, we continue to believe that the use of secure messaging does not belong as a mandate in the hospital setting.** Our members do not believe this is germane in the hospital setting for most patients and we continue to worry that this sets a precedent for encouraging patients to visit the hospital when the more appropriate course is to direct them to their primary care physician or clinician who directs the majority of their care. Finally, there is no discussion in the measure as to whether the content of the message must be clinical. **Should CMS retain this measure, we urge the agency to permit providers to communicate non-clinical information in counting what meets this measure (i.e. scheduling surgery).**

The last measure in this objective involves PGD and calls for more than 5% of discharged patients' health data or data from non-clinical settings to be included in a provider's CEHRT. **CHIME strongly opposes the requirement and believes that including this as a mandatory requirement in Stage 3 is premature and should be removed.** We worry that not all vendors are prepared for this change and while many vendors are moving in this direction to include this capability, it appears largely aimed at the ambulatory community. While we believe in the power of PGD and the promise that certain patient data has to help drive better care, we also know that in order for that to be true technology that is capable of supporting the necessary workflow and seamless inclusion into CEHRT is critical and we do not believe that we are at the point where we can say most hospitals across the board have this. In fact, it is just the opposite. Some vendors, for instance, allow you to enter demographics but are not well-positioned to perform this higher function and truly "engage" the patient.

Further, we do not believe the case for mandating this in the hospital setting has been clearly established and our members have questioned the utility of requiring this of hospitals. We believe this mandate, if adopted, could be particularly burdensome on community hospitals. Finally, there are serious concerns within the clinician community with liability and what it means to accept PGD. We have been told that CMS will accept as counting towards this measure patients bringing paper spreadsheets of their data with them and that scanning these into an EHR will count as PGD. While we appreciate that this could help providers meet the measure, we question the utility of incorporating more unstructured data when it is not

easily extracted or integrated into the EHR and the ability to impact improved outcomes through data incorporated in this manner on a wide scale basis seems limited.

D. Health Information Exchange

Measure one under the health information exchange (HIE) objective calls for providers, when transitioning or referring a patient to another care setting, to create a summary of care (SoC) using CEHRT and to electronically exchange the SoC. **CHIME strongly supports CMS' proposal to reduce the threshold from more than 50% to more than 10% for Stage 3 for Medicare EHs and CAHs.** We applaud CMS for taking this step and believe this will offer much needed flexibility as providers continue to work on exchanging health information.

For measure two for transitions of care or referrals received and patient encounters in which the provider has never before encountered the patient, the EH or CAH must incorporates into the patient's CEHRT an electronic SoC. **CMS has also called for reducing the threshold for this measure from more than 40% to greater than 10%, something CHIME also strongly supports.**

The third measure under the HIE objective calls for clinical information reconciliation. Specifically, this measure calls upon providers to perform medication, medication allergy, and current problem list reconciliations for patients who are transitioned and referred for more than 50% of patients, down from a previously adopted threshold of more than 80%. **CHIME strongly supports the lower threshold and thanks CMS for this.**

E. Public Health and Clinical Data Registry Reporting

CHIME appreciates that CMS has proposed to reduce the number of measures a Medicare hospital must meet under the public health and clinical data registry reporting objective from four to three, however, we continue to believe for a number of reasons that hospitals should only have to meet two measures.

Significant complexity persists around capturing and reporting registry data. While most providers currently capture a significant amount of data in a discrete manner, registry reporting still relies heavily on manually abstracted data. In addition, registries generally have no common data standard and many of them require use of their own custom software or manual data entry into their own portal. This means that each one will need to be custom developed by the EHR vendors and will be an additional cost burden to providers. We appreciate the need to promote registry reporting, however, **any mandates must be preceded by proven, common data standards that are broadly available in the EHRs and implemented by the registries.**

Conclusion

CHIME welcomes the opportunity to comment on this rule and is pleased to have seen CMS make a number of changes requested by our members. We continue to avail ourselves to CMS to further

improve the Meaningful Use program and technology that supports it. Please direct any questions about our comments to Mari Savickis, Vice President of Federal Affairs at msavickis@chimecentral.org.

Sincerely,

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