June 13, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Administrator Verma:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit comments regarding the proposed rule, *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices,* published by the Centers for Medicare & Medicaid Services (CMS) on April, 28, 2017 in the *Federal Register*.

CHIME is an executive organization serving more than 2,300 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation.

CHIME appreciates the opportunity to lend our perspective; our comments will be limited to quality reporting, Meaningful Use, use of certified electronic health records (CEHRT), and CMS' request for information on regulatory flexibilities. We are very pleased to see CMS has listened to our concerns with full-year reporting and has proposed shorter reporter periods under both the Meaningful Use program and electronic clinical quality reporting (eCQM) programs. That said, we have several

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remaining concerns, that if not addressed quickly, risk placing the provider communities in a position where they could face substantial financial penalties. We discuss these concerns in more detail below. In the near-term, we remain very concerned with the requirement for providers to use 2015 Edition CEHRT and the pending requirement to begin meeting Meaningful Use Stage 3 measures starting January 1, 2018. Also, a final set of requirements around eCQM reporting for hospitals is needed as soon as possible to bring stability for providers. **We urge CMS not to require the mandatory use of 2015 Edition CEHRT and mandatory reporting of Stage 3 measures any sooner than 2019. Further, we urge CMS to finalize the quality reporting requirements for 2017 and 2018 as soon as possible, which should include a 90-day reporting period of the hospital's choosing.**

I. 2015 Edition CEHRT, Stage 3 Meaningful Use, and the Drive for Interoperability

A. January 1, 2018 Deadline for Using 2015 Edition CEHRT & Meeting Stage 3 and Stage 3-like Measures

CHIME has been an avid supporter of digitized health information to support care delivery and we have repeatedly acknowledged that the Health Information Technology for Economic and Clinical Health (HITECH) Act was pivotal in speeding use of electronic health records (EHRs) across hospitals and physician offices nationwide. We also believe that providers' use of technology will continue to evolve as technology matures and as providers become more skilled with its use. Understandably, the requirements providers are held to should also evolve; however, they must do so in a manner that leaves adequate time for providers to absorb the pace of change. Further, providers should only be required to meet measures which have been well-documented in improving patient outcomes. CHIME members are very apprehensive about the looming requirement that mandates use of 2015 Edition CEHRT starting January 1, 2018. This issue, combined with the requirement that providers begin meeting Meaningful Use Stage 3, places many hospitals at significant risk of a penalty.

We worry some providers will not have products delivered in time to meet the January 1, 2018 deadline. CMS estimates more than 85 percent of hospitals and only 74 percent of eligible professionals will be ready for 2015 Edition CEHRT by the end of 2017. CMS relied on ONC's retrospective data examining the move from the 2011 Edition to the 2014 Edition; 90 percent of products were certified by the end of 2014 and CMS expects a similar level of readiness for the 2015 Edition. The 2015 Edition CEHRT contains a greater level of development and complexity for vendors. At last review, the Office of the National Coordinator (ONC's) Certified Health IT Product List (CHPL) finds only 73 products are certified for the 2015 Edition. This still represents less than one percent of the overall products certified for 2014. Looking back to approximately this time last year, in July 2016, 4,250 of 4,474 hospitals participating in the EHR Incentive Program were using 2014 CEHRT. Ten EHR vendors supplied 2014 CEHRT to 98 percent of hospitals. Of these ten vendors, two make up just under 50 percent of all hospital certified products and both vendors still have not received certification yet from ONC.

Because so few providers have received their upgraded CEHRT, we remind CMS about the importance of allowing adequate time for providers to deploy the new software and incorporate any required workflow changes. Many of our members have already signed contracts and purchased the new software and / or upgrades and thus are readying for the new technology. Many who have been told when they can expect their upgrade have seen dates shift. Others, however, still don't know when they can expect their upgrades to be delivered and when they query their vendor on an estimated delivery date, they are not given answers. According to a small survey we conducted, 81 percent of members surveyed have not yet received their 2015 CEHRT. More than 70 percent say they do not plan on receiving their updated software by July 1. And, more than 70 percent say they will not be ready for the January 1, 2018 compliance date. It can logically be concluded that since the vendors need more time, so do the providers.

We continue to impart the importance of allowing both vendors and providers adequate time to both develop and deploy solutions. We reiterate our suggested timelines as affording adequate time to develop and test for a major upgrade. This does not include the time it takes for a provider to deploy the solution. Providers, depending on their size, need anywhere from 8-18 months to install software prior to the start of a reporting period to make the necessary workflow and training changes. Finally, the current cadence of change is adding to development and deployment times, as well as, the total operational costs of every healthcare organization.

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Adding to the uncertainty around meeting a January 1, 2018 deadline are other CMS programs that require the use of CEHRT. A quick scan of several other CMS programs include, but are not limited to, the Comprehensive Primary Care Plus (CPC+), the Medicare Shared Savings Program (MSSP), and MIPS which all require the use of 2015 Edition CEHRT beginning in 2018. This interlocking set of requirements means that providers are in jeopardy of failing not only Meaningful Use but several other programs that require this new version of CEHRT. Unless providers are permitted to continue using 2014 Edition CEHRT, they will be at a significant disadvantage and this may unnecessarily result in reduced reimbursement, not to mention the patient safety implications of a rushed installation.

Finally, we question whether the CEHRT testing bodies can move the number of products through the certification process at the very end of the year and request that CMS take this factor into consideration as well. Recent developments have highlighted the need for more rigor in the certification testing process and ensuring there is adequate focus on patient safety. We are concerned these needed improvements will further lengthen the time required for vendors to complete the process.

For the multiple reasons outlined below, we strongly recommend that CMS:

1) **Permit both the use of 2014 and 2015 CEHRT in 2018;**
2) **Allow providers to continue meeting Meaningful Use Stage 2 and Stage 2-like measures at least another year through 2018;**
3) **Provide adequate vendor development lead time and provider implementation time before requiring a new version of CEHRT;**
4) **Align reporting requirements around the current version (2014 Edition CEHRT) rather than continuing to mandate use of 2015 Edition CEHRT in 2018 for other CMS programs tied to the use of the CEHRT; and**
5) **Conduct a systematic review in conjunction with ONC on how to capitalize on the provisions in the 21st Century Cures Act to improve interoperability of CEHRT before mandating the use of 2015 Edition CEHRT.**

B. Quest for Interoperability will not be solved by use of 2015 CEHRT or Requiring Use of Stage 3 & Stage 3-like Measures

A persisting challenge facing our community is the absence of ubiquitous data exchange done in a manner that results in contextually appropriate and useful information delivered to physicians to facilitate better decision-making. We believe the root causes for the persistent lack of interoperability include, but are not limited to, immature and only partially usable standards, incomplete health information exchange infrastructure, and the lack of a reliable patient identifier; these will not be solved by a forced march to 2015 Edition CEHRT by January 1, 2018. While ONC has tried to better focus CEHRT on patient safety, usability and interoperability, Medicare rules still force products to be certified to an overly prescriptive set of Medicare requirements that ultimately hinder innovation and take valuable resources away from vendor development time. Taking these factors into account, providers should not be financially penalized when the full solution set for interoperability is not yet available to them.

"Consolidated" clinical document architecture (CCDA) attachments remain a rudimentary way of moving patient data and in their current state do little to inform patient care. Clinicians routinely ignore CCDAs and prefer paper / faxed summaries of care. Vendors also routinely "drop" incoming CCDA attachments. Those that do make it from one EHR to another are typically not "consumed" by the receiving EHR, parked instead in in-boxes awaiting review that often never happens. Moreover, the content of CCDAs remains bulky and is far from a succinct snapshot of the information most clinicians need. Under Stage 3 providers will be required to not only send CCDAs; to avoid a penalty receiving providers must accept these documents, yet, the underlying infrastructure has improved little. It's hard to fathom how pushing providers to send and receive information that is not adeptly incorporated into an EHR will better serve clinical decision-making. Without an agreed upon set of improved standards that allow the CCDA to be fully consumed and provide contextually relevant information, the problems that plague us today will continue to plague us tomorrow.

Adding to these frustrations is that the information contained in the CCDA is not incorporated into the regular workflow of the clinician; most EHRs require them to seek the information in another section of the EHR dataset,

which forces the clinician to spend time hunting for the information, adding to their continued frustration with EHR functionality and usability. Successful exchange of data is only the tip of the iceberg when it comes to challenges faced by physicians. Getting the relevant information - and not the irrelevant information - into the normal workflow of the physician is the only way to ensure that it can be considered as part of their medical decision-making process. So long as information is not part of the workflow, the goal for helping inform clinical decision-making will not be met.

We recognize that CMS' intent with improving interoperability under 2015 Edition CEHRT and Stage 3 rests with the mandatory use of application programming interfaces (APIs). We appreciate and support the need for patients to readily have access to their information. We nonetheless believe mandating the use of APIs is premature. There are no standards for open APIs inviting more, not fewer, interoperability and security challenges and costs for providers. Even our members who are on the forefront of mobile app use report they are still in a development environment and production is planned for later this year. If the more sophisticated providers are not yet ready for open APIs, it seems reasonable to assume that the smaller and less resourced ones will not be ready either. Further, there are persisting concerns with the security of APIs. The recent Health Care Industry Cybersecurity Task Force report published by the U.S. Department of Health & Human Services (HHS) and submitted to Congress concludes, "Regulatory mandates that will force all EHR vendors to have a shared, publicly-available application interface could expose EHRs to additional attack vectors." Testing on a small scale, the use of APIs could offer some valuable lessons learned prior to immediately moving forward with a full-scale national deployment.

We urge CMS to prioritize the root causes that are hampering interoperability by working with ONC to:

1) **Pilot test the use of APIs on a small scale before requiring wide-scale national use;**
2) **Drive the identification and use of a named set of standards in priority areas to ensure providers are capturing and exchanging data in the same fashion and so that clinicians have the appropriate information presented to them as part of the normal workflow to facilitate better clinical decision-making;**
3) **Support work underway in the private sector to locate a patient identification solution (see comments under RFI section); and**
4) **Increase efforts to ensure all healthcare providers (i.e. long-term care and behavioral health) are able to seamlessly exchange relevant information to improve care coordination.**

II. eCQMs

CHIME appreciates CMS' eCQM reporting proposals which call for shortening the eCQM reporting periods in both 2017 and 2018, reducing the number of measures that must be reported, and better aligning the Inpatient Quality Reporting (IQR) program with the quality reporting requirements under Meaningful Use**.** Under rules finalized last year, CMS requires that hospitals report eight measures for an entire year and that they be submitted electronically. Under the proposed rule, CMS has called for shortening the reporting period to any two quarters in 2017 followed by the first three quarters of 2018 and reducing the number of measures that must be reported from eight to six in both 2017 and 2018**. While we appreciate this proposal, we nonetheless have remaining concerns which we describe below.**

Recognizing that CMS' proposal was aimed at easing some of the burdens on providers, CHIME fears this intended relief could be muted due to other confounding factors that could impede hospitals' ability to take advantage of the flexibilities CMS has offered. First, eCQM reporting flexibility does not dovetail with the start date for 2015 Edition CEHRT use. While CMS permits providers report eCQMs for less than a year in 2018, it nonetheless still requires they report them for the first three quarters of 2018, which requires the use of 2015 Edition CEHRT. As noted earlier, we do not expect providers or vendors to be fully prepared to use 2015 Edition CEHRT by the start of 2018. We also want to impart our concern that implementing CEHRT does not automatically create the ability to submit "appropriate" quality data. There is much process change and documentation review that needs to occur to ensure that the information is being entered into the EHR correctly so that it can be electronically reported out. There are

also audit and review processes that need to be established to ensure the accuracy of the patient population that is included in the quality measure.

While most of our members have already signed, or are in the process of signing contracts to secure purchase and use of 2015 Edition CEHRT as we noted above, this has been a rushed, costly and stressful process for hospitals. It should also be noted that some CEHRT are incapable of handling eCQMs. Some of our members report that their vendors are not certified to submit eCQMs. Others members have vendors capable of handling the eCQMs but have been forced to purchase expensive third party solutions because using their CEHRT would be even more costly. This cost-shifting to the end-user is not sustainable. We believe it is a fair expectation that the CEHRT our members have purchased should be able to handle this process and do so with little added cost. **We urge CMS to permit hospitals to continue using 2014 Edition CERHT for 2018 and to allow them to report on a single, self-selected quarter for 2017 and 2018.**

As we have expressed to CMS in the past, greater alignment between public and private payers is needed to reduce duplicity and waste in our system. Our members typically interact with twenty payers on average, creating a myriad of often very similar measures for which they must report. We also continue to believe it's premature to mandate eCQM submission due to the numerous complexities associated with this process and they should remain voluntary. Some of our members are further along in their eCQM journey than others. Many believe that to be more successful at this process, there must be less reliance on the clinical documentation as unstructured data. The dilemma is the current state of technology is largely incapable of parsing through this unstructured data for quality reporting (and other) purposes. Thus, physicians are increasingly forced into more "checkbox" documentation to capture data needed for quality measures, which increases their frustrations with EHR usability. This speaks to a larger issue around care coordination and the need for seamless exchange of data presented in a contextually appropriate context. And, without timely feedback data it is hard for providers to make changes in a timely manner.

We are also seeking clarification on CMS' Extraordinary Circumstances Exception (ECE). CMS has said they do not plan on making changes to the policy they finalized last year. While the agency notes that this policy applies if a vendor is not certified, it is unclear how providers will be treated if their vendor delivers their 2015 Edition CEHRT so late that it renders a provider's ability to meet the January 1, 2018 deadline moot.

Finally, we call on CMS to finalize eCQM requirements for 2017 as soon as possible. Our members urgently need clarity from CMS to benefit from the proposals. Unless CMS quickly finalizes their proposal for a shorter reporting period and fewer measures, hospitals will have no other choice but to continue their sprint to complete the work necessary to meet the requirements that are still in place today. Therefore, any additional time that CMS can offer for reporting measures will be welcomed so that implementations are not rushed and so that there is more time for deployment, workflow changes, and training.

With these concerns in mind we recommend CMS:

1) **Permit hospitals to continue using 2014 Edition CERHT for 2018 and to allow them to report on a single, self-selected quarter for 2017 and 2018;**
2) **Reduce the number of eCQMs required for 2017 and 2018 reporting to four, the same number required in 2016;**
3) **Keep eCQM reporting voluntary;**
4) **Allow hospitals to file for an ECE if their vendor delivers there 2015 Edition CEHRT so late as to render it impossible to meet January 1, 2018;**
5) **Finalize changes associated with 2017 and 2018 reporting as soon as possible to bring stability for providers;**
6) **Focus on reporting where there has been demonstrated clinical benefit;**
7) **Work aggressively with the private sector, and across federal programs, to arrive at a succinct set of measures that reduce the measure reporting burden for providers; and**
8) **Provide timely access to performance data.**

III. Request for Information on "CMS Flexibilities and Efficiencies"

CHIME is pleased to respond to CMS' Request for Information (RFI) seeking feedback on ways to reduce the regulatory burden on the provider community. We share CMS' goal of improving patient care, lowering costs,

making the healthcare system more effective, simple and accessible, and ensuring the Medicare Trust Fund is spent appropriately. In addition to our comments above concerning eCQMs and CEHRT, we offer the following additional suggestions.

1. **Common Sense Measurement**: CMS should require providers only be held to measure reporting standards that have a clear evidence base and have been determined on a wide scale basis to improve care and or lower costs. Our members feel that too many of the Meaningful Use, MIPS and quality measure reporting requirements have not been proven to meet either or both goals. Instead, these requirements are burdening healthcare providers and adding unnecessary costs to the healthcare system. A complaint we commonly receive is that there simply has not been the justification for the resources devoted to measurement reporting from a return on investment (ROI) standpoint. By that we are referring to better patient outcomes and lower costs. To date, there has been little evidence presented that the measures selected by CMS for reporting do indeed deliver better care or lower costs.
    a. **Recommendation #1**: Just as CMS uses rigorous criteria based on solid clinical evidence for payment coverage policies, they should apply equally principled criteria to measures for which providers are being asked to report.
    b. **Recommendation #2**: CMS should conduct a study to evaluate providers' perspective on the effectiveness of each measure to help gauge its effectiveness.
2. **Certainty & Consistency:** In this era of measurement reporting, the regulatory landscape for providers has been uncertain. Providers find it extremely challenging to prepare for Meaningful Use, MIPS, and quality reporting when deadlines keep shifting, resources are already allocated and changes are finalized well into a calendar year. The measures, rules, and deadlines providers are expected to meet have changed multiple times and often rules are not well-articulated prior to the start of a reporting period. Taken together, this has created a climate of tremendous uncertainty for providers. Adequate lead time to prepare for any reporting mandates including use of 2015 Edition CEHRT and Stage 3 / Stage 3-like measures is paramount. This is only complicated by the fact that providers are contending with a vast array of other regulatory requirements in a healthcare landscape that is rapidly shifting.
    a. **Recommendation:** Retain the same set of measurement requirements (minus clinically based changes) for a minimum of two years.
3. **Meaningful Use Measurement:** CHIME has repeatedly called for several changes to the Meaningful Use program and we appreciate that CMS has taken some of our suggestions. However, we feel the program is rooted in a system of "check the box" measures, which our members describe as measuring for measurement's sake and are not yielding better outcomes. For instance, after years of trying to meet the patient portal measure, it became clear that most patients are still uninterested in using it. The provider community has called upon CMS to allow providers to count the use of administrative tasks like scheduling and billing – functionalities desired by patients – however, CMS declined.

    Stage 3 continues the same policies from previous Meaningful Use stages relying on unproven measures which are increasingly being met with resistance by providers for the same reason. For instance, under Stage 3, hospitals will be required to use secure messaging despite pleas from the hospital community that doing so makes little sense in this care setting. Even more concerning is that as the provider community is launched forward into the next era of Meaningful Use, they will be expected to meet measures that demand interoperability when it largely does not exist in a useful form, and much of which remains outside the control of providers. Finally, there is a growing amount of complexity that providers must manage three sets of program requirements: one for Medicare hospitals, an even greater set of thresholds for Medicaid providers, and finally an entirely different set of requirements for Medicare clinicians. This is creating an undue amount of complexity that is a drain on our system. Most hospitals are going to have to thus navigate three sets of regulatory requirements, which adds an undue level of complexity. Recognizing that CMS is bound by statute to carry out requirements that originate in different laws, we nonetheless believe there are opportunities to align program reporting more and reduce burdens on providers.

    a. **Recommendation #1:** Do not require the mandatory move to Stage 3 (and Stage 3-like measures under MIPS) and Version 2015 CEHRT needed to support Stage 3, any earlier than January 1, 2019.
    b. **Recommendation #2:** Immediately remove the pass/fail approach for Meaningful Use.

c. **Recommendation #3:** Establish a 90-day reporting period, of the providers' choosing, for 2017 and beyond for Meaningful Use.
d. **Recommendation #4:** Align to the greatest degree possible the three sets of Meaningful Use requirements, including lowering the thresholds for Medicaid providers and allowing hospital-based clinicians to get credit for using hospital measures for quality measurement under MIPS.

4. **Cybersecurity:** Cyber attacks are highly disruptive and can be crippling to healthcare entities, as illustrated recently during the WannaCry ransomware attack. The attack impacted more than a dozen hospitals in the United Kingdom and countless other entities spanning the globe, reaching a reported 150 countries. Healthcare is deemed a critical infrastructure by the Department of Homeland Security and as such, patient safety and patient data should be viewed as a public good; protecting those things should be a national priority. Additionally, as payment and delivery system reforms propel us towards greater connectivity, new vulnerabilities arise. CHIME members take very seriously their responsibility to protect their systems and patient information, however, they face competing demands for limited resources – upgrading imaging and other clinical technologies, adopting health IT to comply with Meaningful Use, pursuing data analytics to support the move toward population health, and more. Given the growth in federal policies towards increased data sharing, many of which are rooted in CMS, it is critical that cybersecurity remain at the forefront of policymaking rather than an afterthought. As such, policies are needed to help support providers secure their systems and patient data, and policies that reward good cyber hygiene should be developed.
    a. **Recommendation #1:** CMS should look for ways to encourage investment through positive incentives for providers such as: for as those who demonstrate a minimum level of cybersecurity hygiene and mature information risk management program, and those who make measurable progress over time; and offering incentives under improvement activities performance category of MIPS for practicing good cyber hygiene.
    b. **Recommendation #2:** CMS working together with the Office of the Inspector General (OIG) should expand safe harbors for donations of cybersecurity software, training and other tools helpful to small providers in fortifying their cyber hygiene.
5. **Information Blocking:** We recognize that CMS is bound by the MACRA statutory requirements that call for providers to attest they are not engaging in "data blocking." MACRA calls on providers to demonstrate "(through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology." However, CMS requires providers to attest to three statements, the second and third of which extend well beyond what is outlined in the law. We describe in detail our concerns with this approach in our MIPS comment letter dated December 16, 2016, which can be found here. Statement one largely mirrors what is in the statute and CHIME supports this. However, we disagree with requiring providers to meet the second and third attestation statements, which go well beyond what is called for in law and which may be well beyond what is within the control of providers.
    a. **Recommendation:** Require providers attest only to the first statement, which implements what is in statute.
6. **Patient Identification:** As our healthcare system moves toward nationwide health information exchange, we still lack the ability to identify patients with 100 percent accuracy 100 percent of the time. Errors in patient identification impede the ability to accurately foster errors when it comes to matching patients to their medical records. Ultimately, this hampers interoperability, patient treatment, and patient safety. While a congressional ban prohibits HHS from spending funds on implementing unique patient identifiers, HHS should not be precluded from encouraging private sector efforts to locate a patient identification solution. Through the CHIME Healthcare Innovation Trust's National Patient ID Challenge we launched a crowd-sourcing challenge to find a viable and scalable solution to ensure accurate patient identification. Addressing this problem is especially important as health information increasingly flows across unaffiliated providers to coordinate care and as patients increasingly access and share their own data. Ensuring correct patient identification is the first step toward effectively protecting and securing identities and mitigating fraud. And, it is expected to save our system millions of dollars. While HHS is prohibited from establishing a unique identifier, new language contained in the FY 2017 Labor-HHS Appropriation bill committee report demonstrates a growing willingness to support private sector-led solutions. Additionally, Section 4007 of the 21st Cures Act contains language that instructs the Government Accountability Office (GAO) to conduct a

study on patient matching. Given these developments, we believe CMS can play an instrumental role in helping foster a solution driven by the private sector.

a. **Recommendation #1:** CMS should support private sector-led efforts to locate a solution to patient identification and provide technical support.
b. **Recommendation #2:** We encourage CMS to call upon the National Committee on Vital and Health Statistics (NCVHS), a federal advisory committee, to host a hearing discussing the challenges and opportunities associated with accurately matching a patient with his or her records.

7. **Appropriate Use:** Section 218(b) of the Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a program to promote appropriate use criteria for advanced diagnostic imaging services (AUI). The law requires CMS to have started reimbursing providers for advanced imaging only after qualifying decision support had been consulted beginning January 2017. However, CMS is behind in implementing the requirements and has not yet begun enforcing this provision, which will entail the use of a "qualified clinical decision support mechanism" (CDSMs). We appreciate that CMS has delayed the onset of this requirement, however, we worry that the present plan to begin this on January 1, 2018, does not leave adequate time for providers to obtain and install the requisite software. CMS has said they plan on posting a list of qualified CDSMs by June 30, leaving only six months for providers to prepare. CMS has also said that qualified CDSMs must be able to generate a unique identifier at the time the system is consulted that ultimately will be required for placement by the furnishing clinician on a healthcare claim form; however, details on how this would occur have not yet been made available by CMS.
    a. **Recommendation:** We recommend CMS institute the AUI policy no earlier than January 1, 2019, to give adequate time for vendors to deliver products and for clinicians to begin incorporating this into their workflows.
8. **Telemedicine:** The demand for parity in reimbursement for services provided in-person by a physician and those via telemedicine has never been greater. Medicare telehealth and remote patient monitoring reimbursement policies lag those of both state and private payers and thus need to be expanded to achieve the transformational potential that widespread remote patient monitoring (RPM) and telemedicine adoption hold. Geographical limitations currently restrict the provision of telehealth services. The realignment of federal payment structures will be a key factor to increasing access to telehealth services to those patients who desperately need them.
    a. **Recommendation:** CMS should substantially expand its coverage of telemedicine services and expand its coverage policies to support payment and delivery reform efforts.

IV. Conclusion

CHIME appreciates the opportunity to offer our perspective on how to improve both the Meaningful Use and quality reporting programs. And, we look forward to helping CMS continue to identify ways to improve the regulatory climate for providers.

Sincerely,

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

Liz Johnson, MS, FAAN, FCHIME, FHIMSS,
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