CIO Policy Playbook Index

Background       Page 3
2017 Outlook and Predictions       Page 4
Key Policy Dates in 2017       Page 6
Federal Policymaking Process       Page 7
    Executive Orders       Page 8
Getting to Know Federal Policymakers
    Congressional Leaders       Page 9
    Federal Agencies       Page 11
How Can You Help
    Congressional Outreach       Page 13
    Federal Agency Outreach       Page 14
Meeting Tips
    Congressional Meetings       Page 15
    Federal Meetings       Page 16
About CHIME Public Policy       Page 18
2017 Policy Priorities       Page 19
ACA Repeal/Replace Process       Page 23
21st Century Cures Act
    Summary of Health IT Provisions       Page 25
    Statutory Deadlines       Page 29
2017 CHIME Comments & Statements       Page 33
About the CIO Policy Playbook

This playbook serves as a guide for CIOs who want to become more engaged in CHIME’s public policy efforts. It outlines how and why CIOs can work with the legislative and executive branches to shape federal health IT policy. It also outlines some of CHIME’s top advocacy priorities for 2017. Given the fluidity of events in Washington, D.C., this playbook will be updated on a regular basis. You can download the latest PDF version at www.chimcentral.org/playbook.

Why Should CIOs Participate in Policy/Advocacy-related Activities?

Representing nearly 18 percent of gross domestic product (GDP), healthcare garners significant attention from lawmakers and regulatory agencies. Although health IT hasn’t always been in the spotlight, it certainly moved to the political front-burner in 2009 with enactment of the Health Information Technology for Clinical Health Act (HITECH). Since then, nearly all major healthcare laws and regulations have, in some shape or form, impacted the spread of IT systems. Yet for as much attention as health IT now receives in Washington, D.C., congressional staff and federal agency officials often don’t have direct experience in areas where they write policy. Industry experts can provide valuable information about different programs and the real-world impact that policies have on patient care and the health system overall.

Insights from hospital CIOs and other healthcare executives can ensure that those crafting policy are better equipped to understand how providers are implementing electronic health records (EHRs) under the Meaningful Use program, the current state of healthcare cybersecurity, the development of clinical quality measures, the role of health IT in advancing alternative payment models, health information exchange, patient safety, and more. Legislation passed by Congress dictates federal agency authority to regulate the use of health IT, though the manner in which they regulate has often been very prescriptive.

Each House and Senate committee listed on page 10 has jurisdiction over different areas of health IT. If a member of your congressional delegation sits on any of these committees, there’s a higher chance that they will be active on the healthcare issues. Further, federal agencies have different roles in the regulation and oversight of health IT, so there are many players that need continued outreach and education.

Members of Congress and regulators want to hear from people on the frontlines. Your stories about the pluses and minuses of adapting to federal policy could lead to changes that alleviate regulatory burdens, or bring attention to issues that need more oversight or standardization.

It is only through CHIME member expertise that we can improve the regulatory and legislative landscape for health IT.
Outlook and Predictions for 2017

Congress

While efforts to repeal and replace the Affordable Care Act (ACA) have largely dominated the legislative calendar in the early part of 2017, health IT has yet to be a subject to congressional interest in the 115th Congress.

Aside from tackling the ACA, some must-pass legislation like the Children’s Health Insurance Plan (CHIP) need to be addressed this year.

Further, discussion of reforms to the Meaningful Use program, such as a revised timeline or construct changes are likely with a Republican-controlled House and Senate. Additionally, Tom Price, M.D., Secretary of Health and Human Services (HHS), has been sympathetic to clinicians in their concerns about the regulatory burden imposed by the EHR Incentive Program. During his nomination hearings, Price emphasized the need for a regulatory framework that encourages IT adoption and minimizes regulatory burden.

CHIME supports and testified on behalf of a bipartisan bill (H.R. 3120) introduced into the House to remove requirements that the program’s measures get more stringent over time, which would reduce reliance on Meaningful Use program hardship exemption. The CHIME-supported EHR Regulatory Relief Act (S.3173) introduced in 114th Congress by a group of Republican senators known as the REBOOT group, could resurface in the 115th Congress. The bill seeks to build flexibility into the Meaningful Use program. Other Meaningful Use reform efforts will likely be aimed at streamlining the requirements across Medicare and Medicaid Meaningful Use for hospitals, Medicaid physicians and the Medicare physicians in the Merit-based Incentive Payment System (MIPS.) With action taken by the Centers for Medicare and Medicaid Services (CMS) in 2016, there are now three different sets of Meaningful Use requirements providers must navigate.

Cybersecurity is another key issue that Congress will address in 2017. The Health Care Industry Cybersecurity Task Force, established in the Cybersecurity Information Sharing Act of 2015, delivered its final report to Congress in early June. The task force was charged with looking for ways to improve cybersecurity across the entire healthcare industry. The report and the recent ransomware attacks that have impacted the healthcare industry have spurred interest among lawmakers, this includes the introduction of the Medical Device Cybersecurity Act of 2017 (S.1656) to address some of the lingering

Telehealth is another issue that has traditionally received bipartisan support in both the House and Senate. Multiple legislative proposals have been introduced over the last decade, but the Congressional Budget Office (CBO) has expressed concern that increased availability of telehealth would increase federal healthcare spending.

Federal Agencies

President Trump has acted quickly on a campaign pledge to pursue regulatory relief and reduce the administrative burden that federal rules have on various parts of the economy, including healthcare. The president’s initial steps include:

- An executive order to minimize the regulatory burden of the Affordable Care Act (aka Obamacare); and

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• A call to freeze pending regulations and a delay on implementing those that have not yet gone into effect; and
• An executive order requiring that for every new federal regulation implemented, two must be rescinded.
• An executive order reorganizing the executive branch intended to improve the efficiency, effectiveness, and accountability. Tasks OMB director with reorganization of existing agencies and remove "unnecessary agencies."
• An executive order on enforcing regulatory reform agenda that dictates within 60 days of the signed order each agency must name a regulatory reform officer and form a likeminded task force.

Generally speaking, when a new administration comes in, it is often common to slow down the publication of key regulations in order to give them time to review. Additionally, several agency heads are still must be vetted, nominated and confirmed..

Since Medicare and Medicaid cover approximately one in three Americans and CMS is the nation’s largest insurer, covering 100 million lives, its policies have significant impact on the healthcare industry. The agency also has lead responsibility for implementing the Meaningful Use program and the Medicare Access and CHIP Reauthorization Act (MACRA).

President Trump has appointed Don Rucker, M.D., to serve as next National Coordinator for Health Information Technology. Secretary Price has tapped former member of Congress, John Fleming, M.D., to serve in a new role, Deputy Assistant Secretary for Health Technology Reform. ONC is also responsible for overseeing the certification of EHRs, which will continue to garner attention, particularly under a new agenda aimed at reducing burdens on providers.

On the hospital side, changes to hospital quality reporting, including some flexibility in electronic clinical quality measure (eCQM) reporting and changes to the Meaningful Use program timeline and certification needs, were finalized in the Inpatient Prospective Payment System (IPPS) rule, released in early August.

The 21st Century Cures Act, enacted in late 2016, includes numerous provisions around advancing the interoperability of healthcare, a topic that will continue to get attention from both lawmakers and regulatory agencies. One notable provision sunsets the existing Health IT Standards and Health IT Policy Committees and establishes a single Health IT Advisory Committee. The Government Accountability Office (GAO) recently announced their appointments to the new advisory committee, but the industry still awaits some congressional and administration appointments

Cybersecurity continues to gain momentum, especially following the WannaCry and Petya attacks. Momentum has been building to increase attention to patient safety stemming from device security and protecting patient information from data breaches. In the final days of 2016, the FDA published final post-market guidance on medical device security aimed at manufacturers. The Office of Civil Rights continues to wade into the topic of ransomware. The Trump administration has called for overall heightened attention to national cybersecurity threats, including a likely executive order on the topic and an increase in funding for the Department of Homeland Security’s cybersecurity efforts, but it remains unclear how this will impact healthcare policies moving forward.
Dates with Political Implications to Watch in 2017

January
January 3 – 115th Congress Convenes
January 6 – Congress Counts the Electoral Votes
January 20 – Inauguration Day
January 25 – Earliest Possible Date of Repeal/Replacement for ACA by House Committees
January 26-27 – House Republican Conference Meetings

February
February 6 – Traditionally, submission of the President’s Fiscal Year Budget
February 8-10 – House Democratic Conference Meetings
February 15 – Congressional Budget Office Submits Reports to Congressional Budget Committees
February 28 – State of the Union Address

March
March 1 – Deadline to Select Democratic National Committee Chairman
March 15 – Debt Limit Suspension Ends

April
April 10-21 – Scheduled Two-Week Congressional Recess
April 15 – Traditional Deadline for Congressional Budget Resolutions (Not Met in Many Years)
April 18 – Federal Tax Filing Deadline
April 28 – Fiscal 2017 Funding for Most Federal Agencies Expires at Midnight
April 29 – End of President Trump’s First 100 Days in Office

July
July 1 – Start of Many State Fiscal Calendars (Governors Needs to Finalize CHIP, Medicaid Budgets)
July 30 – FDA User Fee RIF Notices to Be Distributed if User Fees Not Passed
July 31 – Scheduled Congressional Summer Recess Begin

August
August 7 – Expiration of Veterans Affairs Program Allowing Veterans to Obtain Care From Private Providers

September
September 4 – Scheduled Congressional Summer Recess Ends
September 30 – End of Fiscal Year 2017; Expiration of Food and Drug Administration User Fees; Expiration of Children’s Health Insurance Program (CHIP) Funding; Federal Aviation Administration Funding Authorization Expires;

October 1
October 1 – Start of Fiscal Year 2018

November
November 7 – New Jersey and Virginia Gubernatorial Elections

December
December 14 – House Target Adjournment for 2017
December 15 – Senate Target Adjournment for 2017
Understanding Federal Policy Making

1. Stakeholders advocate for new policies
2. Law enacted by Congress that needs implementing rules
3. Agency prepares Notice of Proposed Rulemaking (NPRM)
4. Publish NPRM in Federal Register for public to comment
5. Public is given a timeframe to comment (30, 60, 90 days, etc.)
6. Agency reviews comments and writes final rule based on input
7. Office of Management and Budget (OMB) reviews the final rule
8. Agency publishes final rule
9. Public/industry must comply with final rule by given deadline.
Executive Orders: 101

The Use of Presidential Executive Orders
A president may use authority through an executive order (EO). An EO is generally directed to and governs actions by government officials and agencies. The president’s authority for an EO must be granted by an act of Congress or must be discerned by the Constitution. If the EO is consistent with an express or implied delegation of authority to the executive branch under a statute, or even is compatible with the will of Congress, it will have the force and effect of law, including any requirements or prohibitions imposed by the EO.

The concern with EOs is that they may constitute legislative activity where there is no explicit authority from congressional action or the Constitution, which could be construed as a violation of the constitutional separation of powers. An EO can be, and has been, overturned in court because there is no statute or provision of the Constitution that authorizes it. Congress may also revoke all or part of an EO by directly repealing the order, removing the underlying authority of the EO or by precluding the use of appropriations to carry out the EO.

The president may revoke, modify or supersede any executive order. EOs are published in the Federal Register, but it does not require a public notice and comment period before becoming effective. EOs may also instruct the agencies to rescind orders, rules, guidelines and policies from previous EOs.
Getting to Know Federal Policymakers

**Congress**

**House of Representatives**

- **Committee on Energy & Commerce**: Chairman, Greg Walden (R-OR); Ranking Member Frank Pallone (D-NJ)
  - Health Subcommittee: Chairman, Michael Burgess (R-TX); Ranking Member Gene Green (D-TX)
    - Consumer affairs and consumer protection.
    - Health and health facilities (except healthcare supported by payroll deductions).
    - Public health and quarantine.
    - Biomedical research and development.

- **Committee on Ways & Means**: Chairman, Kevin Brady (R-TX); Ranking Member Richard Neal (D-MA)
  - Health Subcommittee: Chairman Pat Tiberi (R-OH); Ranking Member Sander Levin (D-MI)
    - Social Security (except healthcare and facilities programs that are supported from general revenues as opposed to payroll deductions and except work incentive programs).
    - Programs authorized by the Social Security Act, which includes the following: Old-age, survivors, and disability insurance; and Medicare. Voluntary supplementary medical insurance is provided to aged and disabled persons.

- **Committee on Appropriations**: Chairman Rodney Frelinghuysen (R-NJ); Ranking Member Nita Lowey (D-NY)
  - Labor, Health and Human Services, Education and Related Agencies Subcommittee: Chairman Tom Cole (R-OK); Ranking Member Rosa DeLauro (D-CT)
    - Department of Health and Human Services (with exceptions)
    - Medicaid and CHIP Payment and Access Commission, Medicare Payment Advisory Commission

**Senate**

- **Committee on Health, Education, Labor and Pensions** (HELP): Chairman, Lamar Alexander (R-TN); Ranking Member Patty Murray (D-WA)
  - Primary Health and Retirement Security Subcommittee: Chairman Mike Enzi (R-WY); Ranking Member, Bernie Sanders (D-VT)
    - Measures relating to education, labor, health and public welfare
    - Aging, biomedical research and development, individuals with disabilities, public health.
    - Oversight over Food and Drug Administration (FDA), which regulates medical devices; and Centers for Disease Control (CDC), National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Administration (SAMSHA)

- **Committee on Finance**: Chairman, Orrin Hatch (R-UT); Ranking Member, Ron Wyden (D-OR)
  - Health Care Subcommittee: Chairman Pat Toomey (R-PA); Ranking Member, Debbie Stabenow (D-MI)
• Department of Health and Human Services – CMS (Medicare, Medicaid and CHIP); ONC (Meaningful Use Certification); demonstration authority, peer review of the utilization and quality of healthcare services, and administrative simplification.
• Department of Labor - Pension and Welfare; healthcare tax credit; HIPPA, COBRA and consumer protections (With Senate HELP committee)
• Social Security Administration - Old-Age, Survivors and Disability Insurance (OASDI)
  • **Committee on Appropriations**: Chairman Thad Cochran (R-MS); Ranking Member Patrick Leahy (D-VT)
    o Labor, Health and Human Services, Education and Related Agencies Subcommittee: Chairman Roy Blunt (R-MO); Ranking Member, Patty Murray (D-WA)
    o Agriculture, Rural Development, Food and Drug Administration, and Related Agencies
  • **Senate Special Committee on Aging**: Chairwoman, Susan Collins (R-ME); Ranking, Robert Casey Jr (D-PA)
    • No legislative authority.
    • Conduct oversight of programs (like Medicare, long-term care and prescription drug costs), and investigate reports of fraud and waste.

**Other Congressional Leaders to Know:**
Speaker of the House: Paul Ryan (R-WI)
House Majority Leader: Kevin McCarthy (R-CA)
House Minority Leader: Nancy Pelosi (D-CA)
Senate Majority Leader: Mitch McConnell (R-KY)
Senate Minority Leader: Charles Schumer (D-NY)
Federal Agencies with a Key Role in Health IT

Within the Department of Health and Human Services (HHS)
Secretary: Tom Price, M.D.

Centers for Medicare and Medicaid Services (CMS):
CMS Administrator: Seema Verma
- Administers the Medicare program and helps states administer Medicaid and Children’s Health Insurance Program (CHIP)
- Oversees the Meaningful Use Program, Quality Programs

Office of the National Coordinator (ONC)
National Coordinator for Health IT: Don Rucker, M.D.
Principal Deputy National Coordinator for Health IT: Genevieve Morris
Deputy Assistant Secretary for Health Technology Reform: John Fleming, M.D.
- Charged with coordinating health IT work across the nation and is the lead federal agency on overseeing the exchange of health information electronically
- Oversees certification program for Meaningful Use to develop standards for Certified EHR Technology (CEHRT)
- Has authority to develop other certification programs for health IT

Office for Civil Rights (OCR)
OCR Director: Roger Severino
- Privacy, security and identity
- Oversees HIPAA compliance including audits

Food and Drug Administration (FDA)
FDA Commissioner: Scott Gottlieb, M.D.
- Long history of involvement with clinical decision support and medical device data systems
- FDA Safety and Innovation Act

Agency for Healthcare Research and Quality (AHRQ)
AHRQ: Gopal Khanna
- The R&D arm of HHS
- Academic evaluation, peer-reviewed projects on how to improve healthcare delivery
- Set standards for patient-centered medical homes

Health Resources & Services Administration (HRSA)
HRSA Administrator: George Sigounas, M.S., Ph.D.
- Supports safety net providers (i.e. small and rural hospitals)

Centers for Disease Control and Prevention (CDC)
CDC Director: Brenda Fitzgerald, MD
- Involved with process for reporting public health measures under Meaningful Use

Office of the Inspector General (OIG)
- Inspector General: Daniel Levinson Combats fraud, waste and abuse in healthcare sector including auditing on use of EHRs.

National Institutes of Health (NIH)
NIH Director: Francis S Collins, M.D., Ph.D
- Houses the National Library of Medicine (NLM) which coordinates clinical terminology standards

Other Federal Agencies:
- National Institute of Standards and Technology (NIST) – develops standards
- Federal Communications Commission (FCC) – oversees broadband issues
- Federal Trade Commission (FTC) – oversees competition and business practices, consumer protection
How Can You Help?

Congressional Outreach

Write a letter to your member(s) of Congress
Constituent letters are a great way to voice your opinion on or concerns about an issue. Members of Congress want voters and large employers in their district/state to express their opinions on issues. After all, they are elected to represent the interests of voters in their district/state in Congress. You can send emails through the member’s website, or you can contact CHIME for the email address of the member’s health legislative aide. This email should have a clear message – focus on your main issue and your proposed solution (if you have one). See the list of meeting questions below to help write a constituent letter. CHIME public policy staff can help revise your letter if needed.

Call your member(s) of Congress
Don’t be afraid to pick up the phone and call your representative or senator(s) to give them feedback on an issue you have related to a federal policy. Whether it’s cybersecurity, Meaningful Use or another issue, members of Congress have staff prepared to listen and address your concerns. Create a few talking points to share when you are on the phone and emphasize the reason why the member should be concerned about the issue and how they can take action (if applicable). Take some time to follow up with an email (to provide materials/further evidence) or another phone call to discuss any actions (or lack thereof) from the member.

Set up an in-person meeting
You can call or email an office to ask for a meeting. If you have trouble finding the right contact information, please contact CHIME to help you get that information. CHIME public policy staff can attend your meeting in D.C. if desired. In-person meetings give you more time to express your concerns on a policy and allow you to get better feedback from the member or their staff. You do not need any specific policy expertise to have a meeting – you just need to communicate how a policy affects your hospital/system and/or community. Prepare some materials for an in-person visit. For example: a short bio; background information on your hospital/health system – how many people you employ and serve, etc.; information on your community; a list of awards and recognition your organization has received related to technology; and any fact sheets you have related to your organization. CHIME public policy staff can assist with the creation of a “Hill packet” for meeting(s) in your state or in Washington, D.C. After your meeting, send a thank you note to the person you met with emphasizing the points/concerns you expressed during your visit (see the notes below for more information on why you should follow up).

Host a site visit
Contact your representative or senators’ local offices to invite them to your hospital(s). If they accept the invitation, give the person/people a demonstration of your electronic health records system, telehealth capabilities and/or other electronic features that improve patient care. During the visit, you can discuss workflows, investments in technology and training and other aspects of health IT. While site visits are a great way to showcase how health IT is impacting patient care, you should also use the opportunity to detail challenges presented by the current regulatory climate. Be sure to send a thank you note to the member/staff that visit your facility.
Federal Agency Outreach

Communicating with Federal Agency Staff
Generally speaking, agency staff are concentrated in the Washington, D.C. area.

- Emailing agency staff is one of the best ways to express your concerns about a topic/policy. If you have trouble finding the right information, please contact CHIME public policy staff to help you identify the appropriate agency office and contact person to communicate your concern.
  - Or, if you prefer to remain anonymous and still share your concerns, CHIME public policy staff can serve as a go-between.
- There are also 10 regional offices within HHS and each state is assigned to a region. It can be helpful to establish relationships with these offices on issues of interest (i.e. Meaningful Use). A list of regional offices can be found at: https://www.hhs.gov/ash/about-ash/regional-offices/index.html?language=es.
- If you are interested in speaking to agency staff on a particular issue, please contact the CHIME public policy staff to help facilitate a meeting. Agency staff benefit when they hear directly from the providers they regulate.

Participate in an Agency Town Hall, Listening Session or Other Phone Call
Agencies hold “town hall” calls throughout the year to give providers/the public the ability to comment on programs or proposed programs. These “listening sessions” are not presentations from agencies, rather they are reserved for public feedback on the chosen topic. There are often opportunities to participate not only as an attendee but potentially as a panelist. One way to stay plugged into CMS’ calls is to sign up for their listservs. More information is available here: https://www.cms.gov/About-CMS/Agency-information/aboutwebsite/emailupdates.html

Volunteer to Help CHIME Comment on Federal Regulations
During the public comment process, CHIME reviews proposed rules and creates CIO workgroups to discuss the practicality of the proposed regulation. CHIME workgroups need representation from a broad set of stakeholders to accurately represent the needs of our membership. Member participation has led to tangible changes by regulators and makes for a more impactful letter, therefore, we encourage members to join these.

Along with the comments CHIME will submit on behalf of the broader membership, you can individually or with your organization, submit comments of any length or formality through the Federal Register.

Join a Federal Advisory Committee or Workgroup
These committees make policy recommendations to ONC. Healthcare professionals have the opportunity to apply for volunteer positions in these committees and workgroups once a year. They often hold hearings – in which they call on industry experts to testify – to gather more information for policy recommendations. Please contact the CHIME public policy staff for more information on joining a FACA committee or workgroup.
Meeting Tips

Congressional Outreach
Do your homework. Make sure that you know where your member(s) of Congress stand on key issues before making contact. This background information will help you craft your messages and help you understand if they have supported healthcare-related bills in the past. CHIME public policy staff can assist you.

Below are some basic questions to ask yourself/your staff before a meeting:

- What is currently happening in healthcare and health IT policy around you?
- What do you want to accomplish with this meeting?
- What challenges will you talk about during your meeting?
- How is a certain policy affecting your organization? Your community?
- What kind of issues do you anticipate coming up in the future?
- Is there anything that’s not being addressed by current policy? (Are you looking for more regulation or standardization in a certain area?)
- Who else cares about this issue (patients, providers, privacy advocates, vendors, etc.)?
- What are the financial implications of this program or potential policy on your organization? How much will it cost if no action is taken on this issue?
- What kind of changes/actions/oversight are you looking for to fix the issue? **This is a very important question. Having a concrete “ask/solution” helps the person visualize/benchmark success on an issue.

Important Points for Your Meeting:

- Exchange cards so you can send a thank you note after the meeting.
- Make sure the meeting is a conversation and not a lecture.
- Allow the person to ask questions and get clarification on the topics you discuss.
- Stress that you are a constituent and that you are a practitioner/implementer of health information technology with practical experience related to the topic you discuss.
- Let them know that you care about program success and better outcomes for your community through the investment in health information technology.

Tips for Phone, In-Person Visits and Site Visits
At the end of the meeting, thank the person for their time. You should offer yourself as a resource if they have questions in the future – and say that you are available to give testimony on health IT issues. You can also offer a site visit to demonstrate electronic health record systems or any other systems of interest. No later than 48 hours after the meeting, send a thank you note. Stay in touch and try to build a relationship; doing so could make you a go-to resource when the staffer has a question about health IT policy.
Federal Agency Outreach
Here too, do your homework. It is important to have a working knowledge of what’s happening in the rulemaking process. Are you meeting about a proposed regulation? Are you concerned about how the agency is implementing a final rule? Also, know which law created the regulatory framework that you’d like to discuss. Expect that there will be certain periods in the rulemaking process where the agency is in “listen only mode” and will not be able to share much information. This occurs when a proposed rule is out for comment but the final rule has not yet been published.

Below are some basic questions to ask yourself/your staff before communicating with agency staff:

- What is currently happening in healthcare and health IT policy around you?
- What challenges will you talk about during your meeting?
- What do you want to accomplish with this meeting?
- How is a certain policy affecting your organization? Your community?
- Who else cares about this issue (patients, providers, privacy advocates, vendors, etc.)?
- What does this program cost your organization?
- How much will it cost if no action is taken on this issue?
- What is the risk to your organization if the agency does not act to change a policy?
- What kind of changes/actions/oversight are you looking for to fix the issue? **This is a very important question – having a concrete “ask/solution” helps the person visualize benchmark success on an issue.
- What kind of issues do you anticipate coming up in the future?
- Is there anything that’s not being addressed by current policy? (Are you looking for more regulation or standardization in a certain area?)

Important Points for your Conversation:

- Try to start the meeting on a positive note. Thank the agency where possible for any relevant recent actions they have taken and acknowledge the challenges they have trying to balance multiple stakeholders’ interests.
- Emphasize how committed your organization is to shared goals (i.e. higher quality of care, use of technology, facilitating care coordination through alternate payment models, etc.) when possible.
- Stress that you are a practitioner/implementer of health information technology with practical experience related to the topic you discuss.
- Emphasize the importance of caring for patients.
- Let them know that you care about the program’s success and better outcomes for your community through the investment in health information technology.
- Try and keep the meeting more of a conversation and less of a lecture.
- Ask questions to elicit feedback to get the conversation started and pause intermittently to take questions.
- Exchange emails and contact information with the staff person/people with whom you communicated so they know how to reach you and so you can send a thank you note.

Tips for In-Person Visits and Site Visits
At the end of the meeting, thank the person for their time. You may want to offer yourself as a resource if they have questions in the future; say you are available to provide more information including giving testimony on health IT issues at Federal Advisory Committee meetings. You can also offer a site visit to demonstrate electronic health record systems or any other systems...
of interest (telehealth, etc.). No later than 48 hours after the meeting, send a thank you note. Stay in touch and try to build a relationship; doing so could make you a go-to resource when the staffer has a question about health IT policy. Offer to follow up in a month or two if it seems like it would be helpful.
About CHIME Public Policy
CHIME Public Policy Program was founded in 2007 and we work alongside our members to provide educational and technical policy leadership to Congress and the White House. Through member-led workgroups, our Policy Steering Committee and Board of Trustees, CHIME serves as the voice of healthcare IT executives, informing and influencing federal policies meant to transform the delivery of healthcare in the United States using information technology.

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How Can I Get Involved in CHIME Public Policy?
The CHIME Public Policy team will often leverage the Washington Debrief, distributed to the CHIME membership by email on Monday mornings to share engagement opportunities with members. Review the Debrief for new workgroups that may form in response to a comment opportunity, policy-related surveys or other resources for CIOs.

Take advantage of CHIME Public Policy Office Hours if you have a specific question or request that you think the CHIME team can assist you with relating to federal policies. Having trouble finding the hardship exemption application? Uncertain about information blocking attestations? How did my senators vote on a bill? Just ask.

CHIME Public Policy will continue both ad-hoc and issue-based workgroups to inform CHIME’s responses to policymakers. Look for opportunities to join a workgroup on telehealth, quality measurement, the Medicare Access and CHIP Reauthorization Act (MACRA)/Alternative Payment Models (APMs) or help craft our response back to CMS or ONC on a specific regulation. These workgroups will either meet weekly for a few weeks, in the case of those in response to a federal regulation, or monthly in the case of issue-specific workgroups.
CHIME 2017 Public Policy Priorities & High-Level Talking Points

1. Cybersecurity
2. Interoperability
3. Patient Identification
4. Medicare Access and CHIP Reauthorization Act (MACRA)/ Alternative Payment Models (APMs)
5. Telehealth
6. Quality Measurement
7. Meaningful Use Program

Cybersecurity:
- The Department of Homeland Security identified healthcare as one of the nation’s 16 critical infrastructure sectors.
- The Health Care Industry Cybersecurity Task Force, which included two CHIME board members, offered recommendations to Congress in early June to improve information sharing and cybersecurity practices within the healthcare sector.
- Medical device cybersecurity issues often top the list of concerns for CIOs and CISOs. CHIME will work with the FDA, as well lawmakers, to try and address this critical topic this year.

Policymakers Should:
- Leverage the Health Care Industry Cybersecurity Task Force Report’s recommendations to improve the cybersecurity posture of the industry.
- Look for ways to encourage investment through positive incentives for those who demonstrate a minimum level of cyberattack readiness and mature information risk management programs; and
- Reduce punitive approaches that treat providers as criminals when they have been victims of cyber attacks despite investing in and practicing good cyber hygiene.

Interoperability:
- In an ideal state, interoperability should enable patient data to: flow between EHRs seamlessly and without effort/investment for each trading pair, and the received data appears within the receiving EHR in a usable, relevant manner for each provider. Even if we have data flowing automatically and seamlessly, if it's not viewed in a usable way at the receiving end then we don’t truly have interoperability.
- The absence of a national solution for linking patients to their healthcare data across disparate healthcare providers continues to impede interoperability and will slow progress toward establishing longitudinal healthcare records.
- While a focus on standards may seem overly simplistic, we firmly believe that a more concrete set of standards are needed to spur even greater innovation in digital health. Unless federal leadership emerges, the status quo will stifle future progress toward an interoperable healthcare delivery system.

Policymakers should:
- Drive the identification and use of standards in priority areas to ensure providers are capturing and exchanging data in the same fashion.
Patient Identification:

- There is a ban established by Congress under the appropriations process that prohibits any federal funding from being used to implement a patient identifier. This ban creates a serious impediment to interoperability of healthcare information.
- As our healthcare system moves toward nationwide health information exchange, this essential core functionality – consistency in identifying a patient – remains conspicuously absent. Our inability to accurately and consistently connect patients to their records is hampering patient treatment and outcomes. As data exchange increases among providers, patient data matching errors and mismatches will become exponentially more problematic and dangerous.
- CHIME created a $1 million challenge to locate a private sector-led solution to patient identification given the current ban. CHIME hopes to announce the winner of the National Patient Identification Challenge before the end of 2017.
- Meanwhile, CHIME will continue pressing Congress to remove the appropriations ban prohibiting the use of federal funding to adopt a unique patient identifier.
- We were pleased that the House included clarifying language in the FY17 Labor-HHS Appropriations Committee report explaining that CMS and ONC can work with the private sector and provide technical assistance to promote patient safety by accurately identifying patients to their health information. CHIME joined 25 other organizations calling for that language to be carried forth for all of FY17 and FY18.
- In the draft FY18 Labor-HHS funding bill, Congress suggested patient data matching be a priority for ONC in 2018. It also called for a study on patient matching relative to Medicare, evaluating the costs, financial and healthcare errors, resulting from the absence of a patient matching solution in Medicare.
- Although the 21st Century Cures Act includes a directive to the Government Accountability Office to study current practices and opportunities for patient matching nationally, we believe that more congressional action is necessary.

Policymakers Should:

- Remove the appropriations ban prohibiting the use of federal funding to adopt a unique patient identifier or modify it so that the nation can move toward a single solution for 100% patient identification. In the meantime, the federal government should support private-sector led efforts.

MACRA/APMs:

- CHIME recognizes that for payment and delivery reform to succeed, we need a high-performing, interoperable and secure technical infrastructure. CHIME strongly support steps CMS has taken to improve the flexibility by which clinicians use health IT to drive better outcomes.
- The first performance year for the programs established under the Medicare Access and CHIP Reauthorization Act (MACRA) is 2017, so Medicare physicians will now be reimbursed based on their participation in the Quality Payment Program, either in the Merit-based Incentive Payment System (MIPS) or an Alternative Payment Model (APM).
- CMS has enabled flexibility in the program by offering multiple paths to compliance, allowing Medicare providers to “pick your pace” for 2017. But given that MACRA lays out an entirely new and complicated regulatory structure, we were pleased that CMS largely approached 2018 as a second transition year in the proposed rule released in June.
- MACRA applies to Medicare physicians and clinicians, but not to other providers like Medicaid clinicians and hospitals creating different rules for different providers.
- In reviewing the MACRA rules, we see a few significant challenges that may impede provider success:
1) the lack of interoperability among and across our disparate health systems;
2) the need for better synchronization across all Meaningful Use programs;
3) more attention on cybersecurity; and
4) vendor readiness

Policymakers should:
• Make 2018, in addition to 2017, a transition year, given that MACRA establishes an entirely new and complicated regulatory structure.
• Stage 3 Meaningful Use-like measures and use of Version 2015 CEHRT should not be required any sooner than 2019, as was proposed in the Quality Payment Program (QPP) proposed rule.

Telehealth:
• Medicare reimbursement policies have not kept pace with doctor-patient encounters occurring outside of a traditional care setting.
• Legal and regulatory barriers affect the ability of providers to initiate or expand their telehealth services. Reimbursement must support providers’ use of the technology they deem best fit to achieve better patient outcomes.
• The wide-scale incorporation of telemedicine and telehealth services, including remote monitoring and doctor-patient encounters outside of a physician’s office, should be included as part of ongoing Medicare reimbursement discussions.
• Current initiatives should be expanded in the reimbursement formulas in Medicare’s alternative payment models.
• A national dialogue must take place concerning the patchwork of state laws and licensure barriers impeding the expansion of telemedicine and remote patient monitoring.
• CHIME supports such legislative proposals as CONNECT for Health Act and the CHRONIC Care Act that seek to expand access to telehealth services for all patients, especially those in federal programs.
• CHIME continues to work with lawmakers to pursue policies that will be budget neutral or, at the very least, won’t raise significant concerns when scored by the Congressional Budget Office (CBO).

Policymakers should:
• Create a more flexible reimbursement policy around the use of telehealth such that Medicare pays providers for using it and supports patient care when and where they need it.

Quality Measurement:
• During the Obama administration, Medicare started down a path of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements by the end of 2016, and 50 percent of payments to these models by the end of 2018. Similar initiatives are underway in the private sector and we fully expect them to grow as policymakers look for ways to curtail healthcare spending. Thus, a robust quality measurement program is imperative.
• Since the future of value-based reimbursement is contingent upon the ability to measure performance and outcomes, we believe a cohesive strategy for capturing and communicating quality in healthcare is needed.
• More innovative thinking and flexibility is needed to allow providers to use the technology solutions they best deem fit to treat their patients, while measuring quality in a fashion
that will improve care delivery and reduce the documentation burden while also meeting the government’s needs.

- Many CHIME members have more than 20 different sets of quality reporting requirements they must meet spanning across federal, state and private sector programs. Hours of work and expertise are sunk trying to meet a patchwork of rules.
- Generating valid, reliable and accurate electronic clinical quality measures (eCQMs) without human intervention is also too often underestimated and very complex.
- Measuring quality should be the byproduct of delivering care, not an end unto itself.
- We were pleased to see flexibility in the eCQM requirements for hospitals proposed for the 2017 and 2018 reporting years included in the final IPPS rule.

**Policymakers should:**

- Work with private payers to continue aligning reporting requirements;
- Reduce the quality measurement reporting period for hospital Inpatient Quality Reporting (IQR) to 90 days beginning in 2017 and keep it to 90 days (as was finalized for 2018) thereafter; and
- Refrain from requiring the reporting of eCQMs until they have been rigorously tested and validated.

**Meaningful Use Program:**

- The federal government has invested more than $35 billion to spur the implementation and adoption of EHRs across the nation. There’s no question, with nearly all hospitals and the large majority of physicians participating in the Meaningful Use program, the widespread implementation has been a success. But there is opportunity to reorient the EHR Incentive Program to better support patient care.
- The check-the-box approach to health IT is severely limiting innovation, frustrating caregivers and increasing costs, and is not the right approach to solving interoperability challenges.
- There are varying sets of requirements for different provider settings and clinician types making compliance exceptionally complicated.

**Policymakers should:**

- Synchronize the various sets of MU rules and MU-like requirements under MIPS.
- Immediately remove the all-or-nothing program construct of the Meaningful Use program.
- Implement 90-day reporting periods for every program year as has been the case since 2014. CHIME was pleased to see a 90-day reporting period finalized for 2018 in the IPPS rule.
- Pause the program at Modified Stage 2 while assessing how best to overhaul the program and do not move forward with Stage 3 of Meaningful Use (as proposed).
- Don’t require use of Version 2015 CEHRT until the vast majority of vendors are certified.
How Might the Affordable Care Act Repeal & Replace Process Work

The future of the Affordable Care Act (ACA) will be determined by a combination of congressional actions and executive branch actions that can impact various provisions of the law.

Congressional Action

The first step toward repeal has taken place; both the House and Senate have begun the reconciliation process that directed the relevant committees to draft reconciliation legislation in a process that will be linked to the passage of the federal budget. While there are many rules for using the reconciliation process, the most significant is that the process can only be used to change laws that are scored by the Congressional Budget Office (CBO), those that cost money or will be taxes. Reconciliation can pass the Senate with a simple majority.

House leadership introduced the American Health Care Act on March 6, 2017. The bill was subsequently considered by the Energy & Commerce Committee and the Ways & Means Committee, then approved along party lines in both committees. The AHCA only addresses provisions that will have a direct savings on the federal budget.

The AHCA removes both the employer and individual mandates, adjusts the subsidies into tax credits and scales back Medicaid expansion. The CBO said the AHCA would reduce the deficit by $337 billion over 10 years, and suggested that AHCA would result in 14 million more uninsured Americans in 2018 and 24 million more uninsured Americans by 2026.

On June 22, 2017, Senate leadership unveiled the Better Care Reconciliation Act of 2017 (BCRA) to repeal the ACA or “Obamacare.” This bill was not approved by the Senate, nor a number of other varying repeal proposals, during a series of votes on the Senate floor in late July.

Congressional Republicans cannot use the budget reconciliation process to remove or adapt provisions like denying pre-existing conditions or essential benefit packages. Such changes would come in a replacement package, which will face Senate procedure that will include potential for a filibuster.

A veto threat does not exist, so reconciliation is not the only option for congressional action. The administration and congressional Republicans have indicated their intentions to follow a three-step process: the reconciliation package, a series of administrative changes that do not need legislation and then a final replacement legislative package. Details have not been released about the second and third steps of the ACA repeal and replacement plans.

Administrative Actions

A president may repeal a regulation that has gone into effect. Doing so, however, requires the same path as issuing a final rule – it must go through the same notice and comment rulemaking.

President Trump has already directed federal agencies to delay the effective dates of rules lingering from the Obama administration. Further the president has also signed an executive order to minimize the economic burden of the Affordable Care Act pending repeal.
The president, as outlined on page 9, can use an executive order, where statutory authority exists. Or, the Trump administration may choose to either enforce or not enforce provisions, such as the Internal Revenue Service (IRS) tax, resulting from the individual mandate and therefore not enforce penalties.
# CIO Legislative Brief – Health IT Provisions in the 21st Century Cures Act

<table>
<thead>
<tr>
<th>Policy Proposal</th>
<th>21st Century Cures Act</th>
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<tbody>
<tr>
<td><strong>Administrative Burdens Imposed by HHS Regulations</strong></td>
<td>Requires ONC to reduce the regulatory and administrative burdens of using EHR technology and relieve physicians of EHR documentation requirements specified in HHS regulations and publish a strategy to reduce the burden within one year.</td>
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<tr>
<td><strong>Specialty Certification of EHRs</strong></td>
<td>ONC also would be required to encourage the certification of HIT for use in medical specialties and sites of service, and to adopt certification criteria for HIT used by pediatricians.</td>
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| **ONC CERT Transparency**             | To help healthcare providers choose HIT products, the proposal establishes conditions of certification and an attestation to the secretary concerning certified HIT products—based on criteria such as:  
- the product’s security,  
- user-centered design,  
- interoperability, and  
- real-world testing has been conducted.  

The EHR Reporting Program is created and will consist of reporting criteria on:  
- the product’s security,  
- user-centered design,  
- interoperability, and  
- conformance to certification testing; among other categories.  

$15 million has been authorized to be appropriate to carry out the grants, contracts and agreements to generate reporting criteria in suggested categories. |
| **Interoperable HIT**                 | Interoperability is defined as: “(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; “(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and “(C) does not constitute information blocking as defined in section 3022(a).” |
Information Blocking

Information blocking means—
With respect to a health information technology developer, exchange, or network, business, technical, or organizational practices that:

- except as required by law or specified by the secretary, interferes with, prevents, or materially discourages access, exchange, or use of electronic health information; and
- the developer, exchange, or network knows, or should know, are likely to interfere with or prevent or materially discourage the access, exchange or use of electronic health information.

With respect to a healthcare provider, the provider knows that the practice is unreasonable and is likely to interfere with, prevent or materially discourage access, exchange or use of electronic health information.

The secretary through rulemaking will identify reasonable and necessary activities that do not constitute information blocking.

Gives the HHS Office of Inspector General (OIG) the authority to investigate and penalize information-blocking practices by:

- HIT developers,*
- health information exchanges and networks,* and
- healthcare providers.**

*Developers, exchanges, and networks found to have engaged in information blocking and submitted a false attestation would be subject to civil monetary penalties not to exceed $1 million per violation.

**Healthcare providers found to have engaged in information blocking would be subject to incentives and disincentives to change their behavior.

ONC would be authorized to refer instances of information blocking to the Office for Civil Rights (OCR) if a HIPAA privacy consultation would resolve the matter.

ONC must implement a standardized process for the public to submit claims of HIT products or developers not being interoperable or resulting in information blocking.

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<tr>
<th>Trusted Exchange Framework</th>
<th>Requires ONC to convene stakeholders to develop a trusted exchange framework and a common agreement among existing networks to exchange electronic health information (i.e., a “network of networks”).</th>
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<tbody>
<tr>
<td>Provider Directory</td>
<td>The secretary would be required to establish a digital contact directory for healthcare professionals, practices and facilities.</td>
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<td>Transmissions to Clinical Registries</td>
<td>Requires certified HIT to be capable of transmitting data to, and receiving data from certified, clinician-led (and other) registries.</td>
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<tr>
<td>HIT Developers as Patient Safety Organization</td>
<td>Extends federal privilege and confidentiality protections to HIT developers who report and analyze patient safety information related to HIT use.</td>
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<tr>
<td>Patient Access</td>
<td>GAO study on patient access to their own protected health information, including barriers to the patient’s access and complications or difficulties providers experience in providing access to patients. GAO has 18 months to submit a report to Congress.</td>
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<tr>
<td>Patient Matching</td>
<td>Requires a GAO report to review policies and activities at ONC and other relevant stakeholders to ensure appropriate patient matching to protect patient privacy and</td>
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</table>
security and ongoing efforts related to those policies and activities within two years of enactment.

Areas of concentration:
Evaluate current methods used in CERT for patient matching:
- Privacy of patient information
- Security of patient information
- Improving matching rates
- Reducing matching errors
- Reducing duplicate records

Determine whether the ONC could improve patient matching by taking steps including
- Defining additional data elements to assist in patient data matching
- Agreeing on a required minimum set of elements that need to be collected and exchanged
- Requiring EHRs to have the ability to make certain fields required and use of specific standards
- Other options recommended by relevant stakeholders

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<tr>
<th>Development of Interoperability Standards</th>
<th>The HIT Advisory Committee assumes a significant focus on standards and implementation specifications in three primary areas with others suggested:</th>
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<td></td>
<td>1. Achieving a health information technology infrastructure, nationally and locally, that allows for the electronic access, exchange and use of health information, including through technology that provides accurate patient information for the correct patient, including exchanging the information, and avoids the duplication of patient records.</td>
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<td></td>
<td>2. The promotion and protection of privacy and security of health information in health information technology, including technologies that allow for an accounting of disclosures and protections against disclosures of individually identifiable health information made by a covered entity for purposes of treatment, payment and healthcare operations.</td>
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<td></td>
<td>3. The facilitation of secure access by an individual to such individual’s health information and access to such information by a family member, caregiver or guardian.</td>
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| Elimination of the HITSC | HIT Standards and Policy Committees are combined into one HIT Advisory Committee, for purposes standards, implementation specifications, and certification criteria relating to the implementation of a health information technology infrastructure. It remains a FACA of at least 25 members. |

| Hardship Exemptions for Decertified EHRs | Providers with EHRs that have been decertified will receive an automatic one-year hardship exemption from meaningful use penalties, regardless of whether they have already used the current five-year maximum; extensions may also be granted by the secretary on a case-by-case basis. |

| Health Software Regulation | Excludes software functions that are intended for:
- Administrative support of a healthcare facility, including processing and maintaining financial records, claims or billing, scheduling, business analytics, practice or inventory management, admissions, analysis of historical claims data, determination of benefit eligibility, population health management and lab workflow
- Maintains or encourages a healthy lifestyle and is unrelated to the diagnosis, cure, mitigation, prevention or treatment of a disease or condition |
• Serves as electronic patient records, including patient-provided information, to the extent that such records are intended to transfer, store, convert formats, or display the equivalent of a patient medical chart
  o As long as the chart was created, stored, transferred or reviewed by healthcare professions or individuals under their supervision
  o Such records are certified under the ONC CERT program
  o Such function is not intended to interpret or analyze patient records, including medical image data, for the purpose of diagnosis, cure, mitigation, prevention or treatment

• Transfers, stores, converts formats, or displays clinical lab test or other device data and results, findings by a healthcare professional with respect to the data and results, general information about the findings, general background information about the lab test or device data, unless such function is intended to interpret or analyze clinical lab test or other device data, results, and findings

• Unless the function is intended to acquire, process, or analyze a medical image or a signal from an in vitro diagnostic device or a pattern or a signal from a signal acquisition system for the purpose of
  o Displays, analyzes or prints medical information about a patient or other medical information
  o Supports or provides recommendations to a healthcare professional about prevention, diagnosis or treatment of a disease or condition
  o Enables the healthcare professional to independently review the basis for the recommendations that the software presents for that it is not the intent that such healthcare professional rely primarily on any such recommendations to make clinical diagnoses or treatment decisions regarding an individual patient

The secretary will not regulate the software function as a device in the case of a product with multiple functions that contain:
  a. At least one of the software functions above or that otherwise does not meet the definition of a device; and
  b. At least one function that does not meet the criteria above and that otherwise meets the definition of a device

Also creates an exception allowing FDA to exercise regulatory authority if the agency determines that the use of the software “would be reasonably likely to have serious adverse health consequences” based on four specified criteria:
  1. Likelihood and severity of patient harm if the software were not to perform as intended.
     ** The exception would apply to EHR systems (and other software that simply creates, stores, transfers and displays data), as well as clinical decision support and other analytic tools.
  2. The extent to which the software function is intended to support the clinical judgment of a healthcare professional.
  3. Whether there is a reasonable opportunity for a healthcare professional to review the basis of the information or treatment recommendation provided by the software function.
  4. The intended user and user environment, such as whether a healthcare professional will use a software function.
21st Century Cures Health IT Provisions Implementation Timeline

Annually

The HIT Advisory Committee, in consultation with ONC, will submit a report to Congress on the progress made during the preceding fiscal year on achieving a health information technology infrastructure, nationally and locally, that allows for the electronic access, exchanged and use of health information and progress on meeting benchmarks. (p. 370)

The HIT Advisory Committee, in collaboration with NIST, will annually and through the use of public input, review and publish priorities for the use of health information technology, standards and implementation specifications. (p.382)

30 days after enactment

No enforcement of information blocking practices or conduct occurring prior to 30 days after the date of enactment can occur. (p.385)

Within six months of enactment

The secretary will submit to the HIT Advisory Committee a report concerning attestations statistics for the Medicare and Medicaid EHR Incentive Programs. (p. 334)

The national coordinator will convene appropriate stakeholders to develop or support a trusted exchange framework for trust policies and practices and for a common agreement for exchange between health information networks. (p.352)

The national coordinator will periodically convene the HIT Advisory Committee to identify priority uses for health information technology. (p.379)

Within one year of enactment

The secretary will develop a strategy and recommendations to meet regulatory or administrative burden deductions. (p.329)

The secretary through noted and comment rulemaking will require, as a condition of certification and maintenance of certification a health information technology developer or entity:

a. Does not take any action that constitutes information blocking
b. Provides assurances that for may constitute information blocking
c. Has published application programing interfaces and allows information to be accessed, exchanged and used without special effort
d. Successfully tested the real-world use of the technology for interoperability (p.335)

The health IT technology vendor must provide the secretary an attestation that the developer or entity:

a. Has not engaged in information blocking
b. Has provided the assurances satisfactory to the secretary
c. Does not prohibit or restrict communication
d. Has published application programming interfaces
e. Ensures that its technology allows for health information to be exchanged, accessed, and used without special effort
f. Has undertaken real-world testing (p.338)

The secretary will convene stakeholders for the purpose of developing the reporting criteria for the Electronic Health Record Reporting Program. (p. 341)

The secretary will award grants, contracts or agreements to independent entities on a competitive basis to support the convening of stakeholders to collect the information required to be reporting and develop and implement a process for reporting under the Electronic Health Record Reporting Program. (p.345)

The national coordinator will publish on its public website, and in the Federal Register, the trusted exchange framework and common agreement. (p.352)

The comptroller general will conduct a study to review the policies and activities of ONC and other relevant stakeholders to ensure appropriate patient matching to electronic health information and survey ongoing efforts related to those policies and activities described. (p.402)

The CMS administrator will provide to the committees of jurisdiction on:

a. Populations of Medicare beneficiaries, such as those who are dually eligible for the Medicare program and Medicaid program, and those with chronic conditions, whose care may be improved most in terms of quality and efficiency by the expansion of telehealth services
b. Activities CMMI which examine the use of telehealth services in models, projects or initiatives
c. Types of high-volume services that may be suitable to the use of telehealth
d. Barriers that might prevent the expansion of telehealth services that are beyond what is in effect as of the date of enactment. (p.413)

The secretary will issue guidance clarifying the circumstances under which, consistent with HIPAA, a healthcare provider or covered entity may use or disclose protected health information. (p. 636)

The secretary, in consultation with appropriate experts, will identify model programs and materials, or (in the case that no such programs or materials exist) recognize private or public entities to develop and disseminate materials for a range of healthcare stakeholders on appropriate use of permitted uses and disclosures, consistent with the standards governing the privacy and security of individually identifiable health information. (p.639)

Within 18 months of enactment

The secretary will make recommendations for the voluntary certifications of health information technology for use by pediatric health providers. (p.333)

The comptroller general will submit a report to Congress on patient access to their own protected health information, including barriers to such patient access and complications or difficulties providers experience in providing access to patients. (p.405)
March 15, 2016

The Medicare Payment and Advisory Commission (MEDPAC) will provide information to the committees of jurisdiction that identifies:

a. Telehealth services for which payment can be made as of the date of enactment under fee-for-service, under Medicare parts A and B
b. Telehealth services for which payment can be made as of the date of enactment under private health insurance plans
c. Ways in which services might be incorporated into such a fee-for-service program

Within two years of enactment

The secretary will adopt certification criteria to support the voluntary certification of health information technology for use by pediatric health providers. (p.334)

[Not later than two years after convening stakeholders] the national coordinator will publish on its website a list of health information networks that have adopted the common agreement and are capable of trusted exchange pursuant to the common agreement. (p.354)

The comptroller general will submit to the appropriate congressional committees a report concerning the findings of the study conducted patient matching. (p.404)

The secretary will publish a report that includes input from experts that examines information available to the secretary on any risks and benefits association with software functions and summarizes findings on the impact of the software functions on patient safety, including best practices to promote safety, education and competency related to the functions. (p.264)

Within three years of enactment

The secretary will directly or through partnership with a private entity, establish a provider digital contact information index to provide digital contact information for health professional and health facilities. (p.357)

Within four years of enactment

The secretary will access performance of grant, contract and agreement participants based on the quality and usability of reports for the Electronic Health Record Reporting Program. (within four years and every two years thereafter.) (p.347)

The secretary will submit to the HELP and E&C committees a report concerning best practices and current trends voluntarily provided by patient safety organizations to improve integration of health IT into clinical practice. (p.396)

Within five years of enactment

The national coordinator (and every three years thereafter) will convene stakeholders to review the existing set of adopted standards and implementation specifications and make recommendations to maintain the standards or phase them out. (p.381)
No deadline provided

The national coordinator, with OCR, will issue guidance on common legal, governance and security barriers that prevent the trusted exchange of electronic health information. (p.390)

The secretary, in coordination with OCR, will issue guidance to health information exchanges related to best practices to ensure that the electronic health information provided to patients is: private and secure; accurate; verifiable; and, where a patient’s authorization to exchange information is required by law, easily exchanged pursuant to such authorization. (p. 398)
2017 CHIME Comments and Policy Statements

Regulatory Activity

Stakeholder Letter to Secretary Price on Meaningful Use (Feb 2017)
CHIME Regulatory Relief Asks of HHS Secretary Price (Feb 2017)
CHIME & AEHIS Comment Letter to NIST on Cybersecurity Draft Framework (Apr 2017)
Letter to NCVHS Requesting Hearing on Patient Identification and Matching (Apr 2017)
CHIME Comments on Hospital IPPS Proposed Rule on eCQMs, Meaningful Use and Reducing Regulatory Burdens (Jun 2017)
CHIME Responds to ONC Draft Interoperability Measurement Framework (Jul 2017)

Congressional Activity

CHIME & AEHIS Letter of Support for the MAINSTREET Cybersecurity Act (May 2017)
CHIME & AEHIT Letter of Support for the CONNECT for Health Act (May 2017)
CHIME & AEHIT Statement for the Record of the Senate Finance Hearing on ‘Examining Bipartisan Medicare Policies that Improve Care for Patients with Chronic Conditions’ (May 2017)
CHIME Statement for the Record of the Medicare Program, Payment Systems, and Extenders (May 2017)
CHIME Statement for the Record of the Ways and Means Committee Hearing on, ‘Protecting Americans’ Identities: Examining Efforts to Limit the Use of Social Security Numbers’ (May 2017)
CHIME Letter of Support for H.R. 3120 that Removes Meaningful Use ‘Escalation Clause’ (Jul 2017)
Testimony before the US House of Representatives Energy and Commerce Committee Health Subcommittee on ‘Examining Bipartisan Legislation to Improve the Medicare Program’ (Jul 2017)