CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

June 15, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3311–P
P.O. Box 8013
Baltimore, MD 21244–8013

Submitted via www.regulations.gov

RE: CMS-3311-P – NPRM on Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 - 2017

The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to submit comments in response to the proposed rule regarding Medicare and Medicaid Electronic Health Records (EHR) Incentives – Modifications to Meaningful Use in 2015-2017, which was published by the Centers for Medicare and Medicaid Services ("CMS") on April 10, 2015.

Since its founding over 40 years ago, CHCANYS has established itself both as the voice of New York State's FQHCs and as the most appropriate avenue through which to coordinate training and support for health centers, by leveraging its strong relationship with, immediate access to, and deep understanding of FQHCs and their communities. CHCANYS' purpose is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high quality community-based health care services including a primary care home.

As New York State's Primary Care Association (PCA), CHCANYS works closely with more than 60 federally qualified health centers (FQHCs) that operate approximately 600 sites serving nearly 2 million New Yorkers statewide. FQHCs are not-for-profit, community-based providers located in medically underserved areas or that serve medically underserved populations. They provide high quality, cost effective, patient-centered primary and preventive health services to anyone seeking care, regardless of their insurance status or ability to pay. FQHCs are leading providers of primary health care in New York State, offering a comprehensive model of care that is associated with demonstrated improved outcomes and reduced costs.

100% of New York State's FQHCs are live on EHRs. CHCANYS runs a robust program of technical assistance to support optimal use of these systems to improve quality of care and patient outcomes. As an agent of the Regional Extension Center operated by the New York eHealth Collaborative and through additional federal, state and foundation grant funding, CHCANYS has provided assisted FQHCs in registering for meaningful use payments and attesting to the Adopt/Implement/Upgrade and Meaningful Use Stage 1 milestones.

Many of our FQHCs faced significant challenges in achieving meaningful use objectives in 2014, due to dysfunctionality in several vendor EHR products, slower than expected development of the statewide health information exchange and cost to providers to connect to their local exchanges, and lack of a second public health registry for providers outside New York City. There is a general sense that the EHR Incentive Program is moving too quickly in holding providers accountable for ever-increasing measure thresholds while many of the EHR products and the external environment are

not ready to support them. In the last few months alone, based on their upgrade experiences in 2014, two health centers have decided to change EHRs, a decision that is never taken lightly considering the expense and effort required. Prior to 2014, we are aware of only 2 health centers changing EHRs over a 7-year period.

Our comments focus primarily on issues that are of particular importance to FQHCs in their efforts to ensure access to high quality, cost-effective, patient-centered care for medically-vulnerable patients and populations.

COMMENTS

We applaud the following changes as recommended in the proposed rule:

- Streamlining reporting by removing redundant, duplicative, and topped-out measures
- Modifying patient action measures in Stage 2 objectives related to patient engagement
- Changing the EHR reporting period in 2015 to a 90-day period to accommodate modifications

All of these changes will reduce the reporting and compliance burdens of meaningful use while enhancing providers' chances of achieving Meaningful Use in each of the next three years, thereby advancing CMS's goals for the program.

While we recognize these positive changes in the proposed rule, there are several changes that cause significant concern.

First, the rule proposes to reduce complexity by requiring all providers to attest to a single set of objectives and measures beginning with an EHR reporting period in 2015. We applaud the provision to allow special exclusions for certain objectives or measures for eligible providers previously scheduled to participate in Stage 1 for an EHR reporting period in 2015.

We remain very concerned about two provisions in the proposed rule:

1. We believe the proposal that all providers attest to a single set of objectives and measures beginning with an EHR reporting period in 2015 introduces unnecessary confusion and accomplishes no substantive change in the requirements for an EP scheduled to demonstrate Stage 1 in 2015. These providers are being asked to attest to "Stage 2 with exclusions", which is basically equivalent to Stage 1. This proposed change in terminology introduces unnecessary complication to the rule.

   We strongly recommend that EPs be allowed to attest to Stage 1 in 2015, rather than attesting to "Stage 2 with exclusions."

2. The "Stages of Meaningful Use Criteria By First Year" presented in Table 2 eliminates a second year of Stage 1 as finalized in prior rulemaking (as shown in Table 1) for any provider who first achieves meaningful use in 2015, 2016 or 2017. Since the program's inception, Medicaid providers could join the program in any year up to 2017 and still receive the full 6 years of incentive payments. And since the Stage 2 Final Rule was issued in 2012, providers have been operating under the assumption that they are entitled to two years at Stage 1 even if they do not attest to their first year of meaningful use until 2017.

This represents a serious setback for providers who will see this as a promise broken, or something akin to "retroactive rule-making".

We, therefore, strongly recommend that providers demonstrating Meaningful Use for the first time in 2015, 2016 or 2017 be granted a second year at Stage 1 prior to beginning attestations at Stage 2.

Second, in the Public Health and Clinical Data Registry Reporting objective, we applaud the proposed revision to remove the "ongoing submission" requirement and replace it with an "active engagement" requirement.

We remain concerned about 2 proposed changes to this objective:

1. We are not in favor of the change to Measure 1 – Immunization Registry Reporting, which now requires bidirectional exchange of immunization data. The vast majority of the FQHCs in New York State are already successfully sending production data to a public health immunization registry, but the exchange is not bidirectional. Since the registries are unable to send and the EHR products are not set up to receive data, any provider who satisfied this measure under the current rule will fail under the proposed rule.

   We strongly recommend that the proposed requirement for bidirectional exchange of immunization data be deleted and that ongoing submission of production data from an EHR to a public health immunization registry satisfy Measure 1 of the Public Health and Clinical Data Registry Reporting objective.

2. Measures 2 – 5 are not available to providers practicing anywhere in New York State outside of New York City. Many providers are, however, establishing connections to non-public Clinical Data Registries in conjunction with Medicaid Waiver projects to improve clinical quality and reduce unnecessary inpatient and emergency room utilization. The majority of FQHCs are currently connected to such a Clinical Data Registry. Rather than performing duplicative effort and expense to connect to an out-of-state certified Clinical Data Registry, we request that CMS and ONC re-open the certification process so that non-public registries already in use may be certified to satisfy Measure 5 for Stage 2 in 2015.

   We strongly recommend that the certification process for non-public Clinical Data Registries be reopened so that providers can leverage existing connections to such registries and avoid unnecessary and wasteful efforts to connect to an additional certified registry.

Third, while we are pleased to see the simplification of the Summary of Care objective, it remains very difficult for community-based providers to engage the specialists to whom they refer to receive the Summary of Care electronically. While EHR vendors have established proprietary health information exchange (HIE) networks that facilitate transmission of the Summary of Care to a provider with the same EHR, in the majority of communities the specialists do not use the same EHR as the referring primary care provider, and it is difficult to interest the specialists in enrolling into the proprietary HIEs. Due to the state of interoperability and the difficulties this poses for information exchange across EHRs, and the uneven availability of NwHIN Exchange and the effort and expense involved in establishing connection to a NwHIN Exchange even when it is available, many providers will continue to have difficulty meeting this objective. In addition, HIEs are neither certified nor capable of providing the numerators needed to demonstrate compliance with this measure.

We strongly recommend that this objective be modified, as the Public Health objective was modified, to include several "active engagement" options that allow a provider to satisfy the objective by reaching interim targets that may be short of full electronic transmission of the Summary of Care record. Examples could include: "exchanging clinical data through a regional health information exchange", or "completing registration to exchange documents through an NwHIN Exchange".

Until EHR products and health information exchanges can truly enable efficient, low-cost interoperability and provide the numerators necessary to demonstrate compliance with this measure, this objective must be modified to a realistic level that is achievable by providers given the current technologies available to them.

Thank you for your consideration of these comments.

Sincerely,

Lisa Perry
Sr. Vice President, Quality & Technology Initiatives

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