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

May 29, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3310–P
P.O. Box 8013
Baltimore, MD 21244–8013

Submitted via www.regulations.gov

RE: CMS-3310-P – NPRM on Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3

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 Stage 3 Meaningful Use Criteria, which was published by the Centers for Medicare and Medicaid Services ("CMS") on March 30, 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 are in part adapted from draft comments prepared by the National Association of Community Health Centers (NACHC). We are focusing 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. We have divided our comments into two categories: general comments, and comments related to specific reporting objectives or measures.

COMMENTS ON GENERAL REPORTING REQUIREMENTS

1. Shorten the EHR reporting period for 2018 to 90 days.

Proposal: The NPRM proposes to require all providers to use EHR technology certified to the 2015 Edition for a full calendar year for the EHR reporting period in 2018.

Comment: As evidenced by the issues related to EHR technology certified to the 2014 Edition, including significant delays and lackluster initial Stage 2 attestation numbers, the development, installation, testing, training, and deployment of new certified technology takes a significant amount of time to get right.

Because of stringent timelines imposed by the original Stage 2 rule and vendors who could not get their certified products out the door fast enough, many 2014 certified EHR products were delayed and subsequently released without undergoing proper quality assurance and control testing. As a result, many health centers who upgraded on time had unstable software, which adversely impacted the operations of their practice and ultimately jeopardized the safety of their patients.

It is for this reason that we strongly recommend CMS establish a 90 day EHR reporting period in 2018. This will allow sufficient time for the vendors to develop the new technology needed to support the Stage 3 rule while also allowing practices sufficient time to upgrade their EHRs, train their staff, and roll out the new software across all of their sites. This change would also be consistent with CMS' recent decision to maintain the 90-day EHR reporting period for a provider's first payment year in the Medicaid EHR incentive program.

2. For eligible providers who work at more than one location but meet MU at a single location where more than 50% of their encounters occur, reduce reporting burden by requiring them to report only on the one location.

Proposal: Similar to the Stage 2 Final Rule, this NPRM requires that EPs must have 50 percent or more of their outpatient encounters during the EHR reporting period at a practice(s)/location(s) equipped with CEHRT. In addition, EPs who work at more than one location must compile and submit data from each of these sites, even if one site accounts for more than 50% of their encounters and they have met MU at that site.

Comments: If an EP has met MU at a location where more than 50% of his/her encounters occur, then the EP has demonstrated that he/she knows how to perform as a meaningful user. Requiring the EP to compile data from other sites is burdensome and has no impact on whether the EP meets the MU standard.

Recommendation: When an EP works at more than one site, and can demonstrate that he/she has met MU at a single site that accounts for over 50% of his/her encounters, do not require the EP to report data on other practice locations.

3. Establish a national tracking mechanism by which Medicaid EPs who are affiliated with FQHCs can be distinguished from other Medicaid providers, and collect this data at the national level.

Comments: Community Health Centers are the largest network of providers in the country yet their participation in the Medicaid EHR incentive program cannot be reliably and accurately measured on a national scale. This is due to the

program's structure (e.g. EP versus organization level) and the fact that EP data is currently tracked by State Medicaid agencies, but does not flow up to the national level.

Recommendation: Develop a national tracking mechanism by which Medicaid EPs who are affiliated with FQHCs can be distinguished from other Medicaid providers. States should report this information to CMS, HRSA, ONC, and NACHC on a recurring basis so progress can be measured and training and technical resources channeled accordingly.

COMMENTS ON SPECIFIC OBJECTIVES AND MEASURES:

1. *Protect Patient Health Information:* Clarify that Security Risk Assessments (SRAs) should be conducted by employers/ organizations, rather than eligible providers.

Proposed Measure**:** Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1).

Comments: Security Risk Assessments (SRAs) are generally not completed by individual EPs, but rather the employer of the EP. Also, while we applaud the availability of free tools and resources from ONC, OCR, and other areas, CMS should recognize these assessments usually require the procurement of specialized technical expertise (e.g. vulnerability and intrusion testing, legal consultation, etc.) which is an added expense to health centers and other provider organizations.

Recommendation: Revise language to recognize that SRAs are conducted by employers/ organizations, rather than individual EPs.

2. *Electronic Prescribing (eRx)*: Adjust the requirements that at least 80% of permissible prescriptions written by the EP be queried for a drug formulary and transmitted electronically using CEHRT.

Proposed Measure: More than 80% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Comments: Many FQHCs continue to serve a high proportion of uninsured and self-pay patients. We recommend allowing for the exclusion of uninsured and self-pay patients, where a drug formulary check is unlikely to be part of a typical workflow.

3. *Computerized Provider Order Entry (CPOE):* Clarify the appropriate use of scribes to do Computerized Provider Order Entry (CPOE), including permitting "Veteran MAs" to continue doing the same tasks they did prior to the introduction of CPOE requirements

Proposed Measures: Over 80 percent of medication orders, over 60 percent of laboratory orders, and over 60 percent of diagnostic imaging orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Comments: We seek further clarification on the use of scribes to enter CPOE. It appears that CMS has broadened the scope of who can enter CPOE in the use of such phrases as "appropriately credentialed," "similar to a medical assistant," "we defer to the provider's discretion." Can CMS add an example speaking directly to scribes, in association to the latitude provided in this section?

Recommendation: We strongly recommend that CMS allow MAs who handled the paper based equivalent of CPOE prior to the Stage 2 Final Rules (Sept 2012), and who are still employed with the same organization where they were as of Sept 2012, to be referred to as "Veteran MAs" and permitted to enter CPOE for MU. Such Veteran MAs were doing this entry

long before conditions of "credentialed" and "by an organization other than the employing organization" were introduced to the MU rules, and they have a thorough understanding of the organization's workflow, employee competency, and clinical staff.

4. *Patient Electronic Access to Health Information (AHI*): Reduce 80% of all unique patients seen to 50%; ensure that measures are attainable through CEHRT, and do not require the purchase of add-on products; increase time permitted from 24 hours to 72 hours; clarify which accounts are included in the numerator for this measure. Create an exclusion where an EP sees predominantly homeless patients without access to a smartphone or computer.

Proposed Measures: For more than 80 percent of all unique patients seen by the EP…:
(1) The patient (or the patient authorized representative) is provided access to view online, download, and transmit his or her health information within 24 hours of its availability to the provider; or
(2) The patient (or the patient authorized representative) is provided access to an ONC certified API that can be used by third-party applications or devices to provide patients (or patient- authorized representatives) access to their health information, within 24 hours of its availability to the provider.

Comments:

We believe that 80% is too high of a threshold, and believe it should be maintained at 50%. In many populations, it is extremely difficult to achieve even the 50% threshold (e.g. homeless patients, patients who for religious reasons do not access the internet, migrant workers). 50% is an adequate threshold to indicate that a provider is making the effort to provide patients with log-ins to access their data. If there is demand in the population served, the threshold will be exceeded.

We believe that the objectives and measures proposed for Patient Electronic Access to Health Information should be attainable by using only CEHRT without it necessitating the need to purchase add-on products such as patient portals, expensive interfaces, etc.; that this functionality should come packaged into the core CEHRT functionality.

While we applaud the introduction of APIs to support data access and patient exchange, they still will require development of add on products that may come at an additional expense to the center and/or patient. In addition, it would seem that employing a standard approach to accessing patient health information (e.g. requiring CEHRT to provide this functionality without purchase of add-on products) has the potential to foster a more convenient, comprehensive, and consistent experience for the patient.

In addition, as noted by RECs during 2014 and 2015, certified EHRs appear to have different interpretation of what allows a patient's account to appear in the numerator for this measure. We recommend that CMS clarify which accounts count in the numerator so that EPs using different EHRs are consistently reporting this measure. The time interval should be extended from 24 hours to 48 hours to allow for the completions of provider notes.

5. Patient Engagement:

- **Recognize the financial and linguistic challenges faced by health center patients, and reduce the degree to which EPs are held accountable for patient behavior that is beyond their control, by lowering the patient engagement thresholds for view/download/transmit (VDT) from 25% to 10%, secure messaging from 35% to 10% [and permit any EP who contributes to a secure patient message (not just the initiating EP) to count that patient in their Secure Messaging measure] and patient -generated data from 15% to 5%.**
- **Reconsider the measure on incorporating patient-generated health data into the EHR.**

Proposed Measure: During the EHR reporting period, more than 25 percent of all unique patients seen by the EP… actively engage with the EHR made accessible by the provider. An EP may meet the measure by either:

(1) More than 25 percent of all unique patients (or patient-authorized representatives) seen by the EP… during the EHR reporting period view, download or transmit to a third party their health information; or
(2) More than 25 percent of all unique patients (or patient-authorized representatives) seen by the EP… during the EHR reporting period access their health information through the use of an ONC-certified API that can be used by third-party applications or devices.

Comments: While we recognize the important role that EPs play in promoting patient engagement, we do not believe EPs should be responsible for patient behavior over which they have no direct control.

Over 70% of health center patients live at or below the federal poverty line and therefore do not have the means to have computers or Internet access in their homes to generate patient data, send and receive secure messages, or VDT their information. Moreover, English is the predominant, and in some cases only, currently supported language by EHR vendors, which poses challenges when engaging patients best served in a language other than English.

For these reasons, we recommend lowering the thresholds for VDT from 25% to 10%.

Proposed Measure: During the EHR reporting period, for more than 35 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient's authorized representative), or in response to a secure message sent by the patient

Comments: Given the financial, linguistic, and other challenges faced by health center patients (as discussed above), we requests that the threshold for secure messaging be reduced from 35% to 10%.

In addition, we recommend that any provider who contributes to the secure message, not limited to the initiating provider, should have the patient count in his/her numerator for Measure 2 Secure Messaging. It is suggested or expected that the EP's comments be clinically relevant, but we cannot impose constraints on CEHRT with an expectation that this level of input be measured. Examples have been provided by CMS that are helpful; however these examples clearly outline the challenges in how CEHRT would have to differentiate the content of the secure message. Such an expectation is not realistic.

Proposed measure: Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15 percent of all unique patients seen by the EP or discharged by the eligible hospital or CAH during the EHR reporting period.

Comments: We question whether patient-generated health information should routinely become part of a patient's medical record simply because we have the technology to make this happen. Information provided by non-clinical setting (e.g. nutritionists, social workers, physical therapists, other members of a patient's care team) might be deemed appropriate by clinical staff to include in an electronic chart, but should be at the discretion of the EP, not the patient or non-clinical personnel or CEHRT. In addition, technical barriers to achieving this objective are likely. Given the requirement that an EP meet 2 of 3 of these measures, we expect the measure relating to patient-generated information will not be embraced by many. Patient-centered communication between and among providers is a worthwhile objective and despite the above comments related to this proposed measure, should not be discouraged.

For these reasons, as well as the financial, linguistic, and other challenges faced by health center patients (as discussed above), we request that the threshold for patient-generated data from 15% to 5%.

6. ***Care Transitions and Referrals*****:**

- **Ensure that all functionality required for meaningful use is part of the core CEHRT and not dependent on the purchase of third party add-on software packages, interfaces, etc.**

Proposed Measures:

- For more than 50 percent of transitions of care and referrals, the EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care:
  (1) creates a summary of care record using CEHRT; and
  (2) electronically exchanges the summary of care record.
- For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital or CAH incorporates into the patient's record in their EHR an electronic summary of care document from a source other than the provider's EHR system.
- For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital, or CAH performs clinical information reconciliation. The provider would choose at least two of the following three clinical information sets on which to perform reconciliations:
  - Medication: Review of the patient's medication, including the name, dosage, frequency, and route of each medication.
  - Medication allergy: Review of the patient's known allergic medications.
  - Current Problem list: Review of the patient's current and active diagnoses.

Comments:

Based on our experience of the difficulty providers have had in negotiating reasonable pricing with EHR vendors for interfaces required with Health Information Exchanges, we feel strongly that to ensure widespread adoption and future sustainability, the functionality required for the meaningful use program should be part of the core CEHRT and not dependent on the purchase of third party add-on software packages, interfaces, etc.

For the clinical information reconciliation measure, it follows that the licensed health care professionals and credentialed medical assistants that can complete CPOE should also be permitted to conduct the reconciliations required in this measure.

Regarding the request for feedback on whether CMS should include utilization alerts when a patient is admitted, seen in the ER or discharged from the hospital should be included in this measure: we recommend against adding this to the Stage 3 requirements, as the cost associated with obtaining this service in our state adds a significant external barrier to achieving meaningful use.

***7. Public Health and Clinical Data Registry Reporting*:**

- **Clarify that public health measures are to be met by the site, not the EP**
- **Finalize the use of the term "active engagement" in these measures**
- **Finalize proposals to create a centralized repository of national, state, and local public health agency (PHA) and clinical data registry (CDR) readiness, and to develop a national infrastructure to support more standardized reporting of public health measures.**

Proposed Measures:

- *Immunization Registry Reporting*: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
- *Syndromic Surveillance Reporting:* The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs, or an emergency or urgent care department for eligible hospitals and CAHs (POS 23).
- *Case Reporting:* The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions.
- *Public Health Registry Reporting:* The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit data to public health registries.

- *Clinical Data Registry Reporting:* The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry.

Comments: We applaud the change from the use of the term "ongoing submission" to "active engagement" which more accurately reflects the nature of a relationship between sites and PHAs/CDRs.

We believe that Public Health measures are met by a site, not each individual EP. Any EP working at a site that meets the requirements should be eligible to attest "Yes", regardless whether that EP administers immunizations, for example. An EP that is licensed and capable of administering an immunization, but does not in his/her current scope of work administer immunizations, is still capable of administering immunizations and using the immunization registry functionality available at his/her place of practice, should an epidemic call for this service, for example. It is important that the EP's site is capable, not whether the EP actually administers immunizations during an MU reporting period.

We also welcome the creation of a centralized repository of national, state, and local PHA and CDR readiness, as well as the development of a national infrastructure to support more standardized reporting of immunizations, syndromic surveillance, cancer, public health and case reporting. We are concerned that state and local public health infrastructure may not be adequate to meet the new EHR certification requirements.

Bi-directional exchange of immunization data is not currently available for immunization registries in New York State. We recommend that bidirectional reporting be required where available.

Thank you for the opportunity to submit these comments.

Sincerely,

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