December 15, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201 1
[Submitted electronically]

Re: CMS-3310-FC and CMS-3311-FC], Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017

Dear Mr. Slavitt:

On behalf of our 126 member hospitals, the Kansas Hospital Association (KHA) appreciates the opportunity to respond to the Request for Comments on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017 published on October 15, 2015 (Federal Register, DOC #: 2015-0033).

Kansas hospitals seek to move toward an e-enabled health care system where all hospitals meaningfully use EHRs to improve patient care and safety and achieve national goals for improved health. We appreciate the focus on interoperability but we caution that there is not yet sufficient experience at Stage 2 to consider Stage 3 proposals to be achievable. It is important for CMS to work closely with ONC to build out the infrastructure on information exchange and to move from standard development to standard implementation.

While we support CMS’s goal to use certified EHRs and other technology to improve the coordination, quality and safety of care for patients, we have serious concerns about the complexity of CMS’s program requirements. These burdensome requirements lead to excessive spending for compliance and an undue focus on meeting meaningful use that could be better spent on patient care. The KHA are very concerned that the proposed Stage 3 requirements raise expectations too high without first addressing the challenges with meeting the existing program thresholds, particularly related to the patient portal, transitions of care and electronic quality reporting. Further, objectives moved from menu to core should not have the threshold increased.

Merit-Based Incentive Payment System
Despite calls to postpone issuing requirements until the overall structure is developed for the new Merit-Based Incentive Payment System (MIPS) mandated by the Medicare Access and CHIP Reauthorization Act, requirements for the stage 3 rule have been released. Many providers have great concern that the Stage 3 rule is too much too soon. Furthermore, revision of the “meaningful user” definition needs to be included in the larger conversation about how MIPS will be shaped and designed.

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For physicians, the MIPS program will introduce significant changes to the physician quality reporting programs, including Meaningful Use. The success of MIPS hinges on the success of Meaningful Use, but not as a “checkbox program”, but rather as a tool that can help to capture and quantify the overall outcomes-based program.

Although the 2015 reporting period changes are welcome and provide providers with some relief, the Stage 3 final rule still raises the bar too high. To support hospitals in meeting regulatory requirements to use certified EHRs, we urge CMS to revise the EHR Incentive Program framework to reflect program experience to date and revise the program measures that providers must meet.

REVISE THE STAGE 3 MEASURES

To meet the Stage 3 objectives, EHs and CAHs must meet 21 measures that raise the modified Stage 2 thresholds and introduce new requirements and functionality. This includes higher thresholds for electronic exchange of summary of care documents that include types of data and requirements to use APIs to support information exchange. Several measures are too ambitious and experience with 2014 attestations prove that they are premature to impose. We urge CMS to postpone implementation of the requirement that providers electronically submit clinical quality measures (eCQMs) and to first learn from the voluntary programs. The following recommendations are specific to the measures required to meet the eight Stage 3 objectives.

**Patient Electronic Access to Health Information.** For measure one, we recommend that CMS not require the use of API functionality in the certified EHR to support patient electronic access to health information. Providers should not be required to accept requests for any app to connect to the certified EHR without a standard for APIs. We also recommend that CMS not require providers to count the number of patients for whom the certified EHR was used to identify and provide electronic access to patient-specific educational resources.

**Protect Electronic Health Information.** We support maintaining the previously finalized measure for this Stage 3 objective, requiring providers to conduct or review a security risk analysis in accordance with the HIPAA Security Rule.

**Electronic Prescribing of Discharge Medications.** We oppose a measure threshold greater than 10 percent, as included in the modified Stage 2. CMS recognized that the generation and transmission of permissible discharge prescriptions electronically was a new requirement for EHs and CAHs in 2015 and provided an exclusion to this requirement for EHs and CAHs in 2015 and 2016. All EHs and CAHs will be expected to meet the objective in 2017, and we recommend that the 10 percent threshold remain in place for Stage 3 to allow the changes in technology and workflow to continue for more than one year.

**Clinical Decision Support (CDS).** We recommend removing the requirement between CDS and clinical quality measures in favor of using CDS to address high-priority safety and quality improvement objectives of the hospital.

**Computerized Provider Order Entry (CPOE).** We support the CPOE measures included in the Stage 3 final rule. We ask that CMS clarify which providers may enter orders electronically to meet the requirement.

**Coordination of Care through Patient Engagement.** For measure one, we recommend that CMS not require the use of API functionality in the certified EHR for the coordination of care through patient engagement. For measure two, we recommend that secure messaging should be a requirement applicable only to EPs. After an acute care visit, a patient is more likely to access information through a primary care provider than from the hospital. For measure three, we believe it is premature to require that certified EHRs receive patient-generated data or data from non-clinical settings from 15 percent of all unique patients because we lack standards to support this measure.

**Health Information Exchange.** For measure one, we recommend retaining the modified Stage 2 threshold that EHs and CAHs use their certified EHR to create and electronically send a summary of care for more than 10 percent of transitions of summary of care. We also recommend that measure one expressly permit the use of health information exchanges to support sending summary of care records. For measure three, we recommend that CMS not require a percent threshold for medical record information reconciliation for new patients. This requirement precedes the readiness of patient matching solutions and the availability of EHR interoperability that supports the exchange.
Public Health and Clinical Data Registry Reporting. We recommend that CMS retain the modified Stage 2 requirements for this objective and continue efforts to support public health agencies in their ability to receive the data in accordance with CMS required standards. We recommend CMS continue to provide alternate exclusions to the measures in the public health reporting objective until the agency has launched a database of available national, regional and state registries to facilitate measure reporting. We also recommend that registries that receive data from certified EHRs be subject to certification as assurance that they are capable of receiving data in the required formats.

REVISE THE EHR INCENTIVE PROGRAM FRAMEWORK

We recommend the following changes to the structure of the meaningful use program:

Postpone the required start of Stage 3 until a date no sooner than 2019. We recommend that CMS hold the current EHR Incentive Program requirements in place until the vast majority of all program participants meet Stage 2. Specifically, the program should not require providers to start Stage 3 until at least 75 percent of eligible hospitals (EH), 75 percent of critical access hospitals (CAH) and 75 percent of eligible providers (EP) have met Stage 2. The start of Stage 3 should not occur prior to the start of the Merit-based Incentive Payment System (MIPS) and Advanced Payment Model (APM), currently scheduled to begin in 2019. The first year of Stage 3 also should include a reporting period of any 90 consecutive days.

Eliminate the all-or-nothing approach in meaningful use. We believe CMS has the authority to reduce the number of objectives and measures that providers are required to meet in order to successfully attest to meaningful use. We recommend that EHs, CAHs and EPs that attest to meeting 70 percent of the meaningful use requirements be considered to have met meaningful use.

Include only mature standards in regulations. Experience to date suggests that required use of immature standards, such as Direct messaging, is not workable. Therefore, it is premature to require providers to use Application Programming Interfaces (APIs) in the EHR to make health information accessible by any application (app) that requests access to the information. While APIs hold promise, and there is a standard to support APIs in EHRs under development, it is not yet proven and use of this functionality should not be mandated.

Provide a hardship exemption from meaningful use penalties for any EH, CAH or EP that changes vendors during a reporting period. A hospital’s decision to change vendors during a reporting period should not place them at risk for penalties. Providers should be held harmless if their vendor is unable to support them in meeting regulatory requirements.

Kansas hospitals are committed to moving toward an e-enabled health care system to improve patient care and safety and achieve national goals for improved health. Greater flexibility in the meaningful use program will enhance our ability to deploy new models of care focused on value Thank you for the opportunity to share our concerns and comments.

Sincerely,

Tom Bell
President and CEO