June 27, 2014

Marilyn Tavenner, RN, MHA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Karen DeSalvo, MD
National Coordinator
Office of the National Coordinator for Health IT
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Submitted electronically at: http://www.regulations.gov

Re: Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014 and Revisions to the Certified EHR Technology Definition

Dear Administrator Tavenner & National Coordinator Dr. DeSalvo:

The College of Healthcare Information Management Executives (CHIME) is writing in response to the proposed rule at 45 CFR Part 170, "Modifications to the Medicare and Medicaid Electronic Health Record Incentive Programs for 2014," published in the May 23, 2014 *Federal Register*.

CHIME is a professional association representing more than 1,400 chief information officers (CIOs) and other top information technology executives at hospitals and clinics across the nation. CHIME members have frontline experience in implementing the kinds of clinical and business IT systems needed to realize healthcare transformation. Our members have a shared vision of an e-enabled healthcare system as described by the many efforts underway at the Department of Health and Human Services (HHS).

CHIME greatly values the relationship with both agencies and appreciates the opportunity to comment on the joint CMS-ONC Notice of Proposed Rulemaking (NPRM). We continue to be a fierce supporter of the EHR Incentive Program and believe strongly in the power of information technology to improve care delivery and constrain healthcare spending.

While CHIME is concerned by the late timing of this proposed rule, given the honest and robust conversations of the last year, we understand all parties are working diligently towards the same goal: to improve the quality, delivery, safety and efficiency of our nation's healthcare system through information technology. With that in mind, CHIME supports the new pathways as defined in the proposed rule. We believe these options will provide needed flexibility for EHR optimization,

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encourage continued participation in the program, and help maintain the upward trajectory of EHR adoption in the US.

However, CHIME strongly believes in order to ensure maximum efficacy, CMS should allow providers to choose any 3-month quarter EHR reporting period throughout the next FY or CY to qualify for Meaningful Use in 2015. We believe this change will have a dramatically positive effect on program participation and policy outcomes sought in 2015. The additional time afforded by this modification would help hundreds of thousands of providers meet Stage 2 requirements in an effective and safe manner. Further, it would serve as positive incentive for those who must seek alternative paths to MU in 2014 to continue their work in 2015. Such a change would also have benefits for cross-program alignment in areas of clinical quality measurement.

Lastly, a number of CHIME members have indicated their apprehension to take advantage of the new pathways created by this NPRM. They are concerned with how this proposed rule defines "full implementation" of CEHRT since the examples listed do not adequately represent their situation. For example, many leading providers are unable to meet Stage 2 "transitions of care" requirements, in particular, because of the high degree of interdependence required among referring partners. **We recommend CMS remove this requirement to take advantage of the new pathways in 2014.** Alternatively, we ask CMS to clarify their proposal to explicitly state their understanding that many different scenarios could prevent a provider from fully implementing a 2014 Edition CEHRT, even beyond those specifically mentioned in the proposed rule. We also ask CMS to convey this understanding to program auditors.

<u>New Pathways to Meet MU in 2014</u>

CMS and ONC propose to create new flexibilities to help providers meet Meaningful Use requirements in 2014, regardless of which Stage they are scheduled. These new pathways would allow providers the option of meeting Stage 2 requirements, 2013 Stage 1 or 2014 Stage 1 requirements; use 2011 Edition CEHRT or 2014 Edition CEHRT; and report on CQMs consistent with the Stage and Edition they choose.

RECOMMENDATION: CHIME fully supports the new flexibilities proposed in this NPRM with the addition of clarifying language and minor changes to proposed CQM reporting requirements. We believe these new pathways will provide much needed relief to hundreds of thousands of providers struggling to meet MU requirements in 2014, due to circumstances beyond their control. In order to fully realize the benefits of these new pathways, CHIME requests CMS explicitly state its intensions to let providers meet MU requirements retrospectively in 2014, if they are able. For example, one new pathway would allow a provider who is scheduled for Stage 2 to use 2011 Edition CEHRT against 2013 Stage 1 requirements, though it is likely this option is only available for providers who can configure their technology to perform a retrospective query. We ask CMS to explicitly bless this strategy as a viable way to take advantage of new flexibilities in the final version of this NPRM.

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Further, we request regulators clearly state their intentions to finalize all changes retrospectively and ensure that auditors do not treat providers who attested before finalization of the proposed rule differently from those who attest after finalization of the NPRM. For example, we are concerned that changes made to MU in 2014 will complicate the auditing process, so we recommend CMS state that "all changes to MU requirements in 2014 will be applied retroactively for the entire year," and "EHR Incentive Payment program auditors will incorporate the finalized changes during their reviews, regardless of when the provider attested in 2014." These additions will help give providers the assurance they need to take advantage of the new flexibilities proposed in this rule.

Lastly, CHIME recommends CMS allow providers the option to report CQMs of their choosing, regardless of the exact Stage of Meaningful Use met. Specifically, hospitals using a combination of 2011 and 2014 Edition CEHRT should be able to report either set of CQMs to meet Meaningful Use requirements in 2014.

<u>2015 Reporting Period</u>

Your agencies propose to maintain the existing policy that all providers must use 2014 Edition CEHRT for the EHR reporting periods in CY 2015, FY 2015, and in subsequent years or until new certification requirements are adopted in future rulemaking. Further, this proposed rule would leave in place requirements that all providers who began MU in 2013 or earlier report against Stage 2 measures and objectives for the entire Fiscal or Calendar quarter in 2015.

RECOMMENDATION: CHIME strongly urges CMS to adopt the 2014 policy, allowing providers to choose any 3-month quarter EHR reporting period, for FY and CY 2015. CHIME believes providers will benefit from the option of reporting during one quarter of 2015, rather than the full year. Most providers who take advantage of the flexibilities proposed in this NPRM will need to report on Stage 2 measures and objectives in 2015, and most of these providers <u>will not</u> be in a position to report a full year of data, beginning October 1, 2014. The 365-day reporting requirements in 2015 will only serve to delay program decline – rending any positive developments stemming from this NPRM moot. Because there is such limited capacity for the industry to absorb ongoing technology upgrades and process changes, CHIME implores CMS to allow 3-month quarter EHR reporting options in 2015.

<u>Full Implementation Attestation Requirements</u>

In the preamble of the proposed rule (page 29734 of FR Vol. 79, No. 100) your agencies include two examples of how a delay in CEHRT availability would inhibit a provider's ability to meet MU requirements in 2014. In order to take advantage of new flexibilities proposed for program year 2014, providers must attest that they are choosing an alternative MU path due to CEHRT availability.

RECOMMENDATION: CHIME recommends CMS omit the "fully implement" attestation requirement. Alternatively, we ask CMS to be expansive in considering scenarios that have created, led to, or resulted in a situation where the provider was unable to "fully

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implement 2014 Edition CEHRT." Further, we recommend CMS to clarify that this requirement (1) will be a step in the familiar attestation process, and (2) no additional documentation will be required as part of this aspect of the attestation process. There is widespread concern among CIOs that program auditors will be overly zealous in determining what implementation and workflow changes merit the ability to take advantage of new flexibility. We appreciate the examples listed in this proposed rule and would urge CMS to give EHs and CAHs additional confidence by expanding those examples to include scenarios "outside the provider's control" such as an underdeveloped ecosystem of exchange participants to receive summaries of care for transitions of care.

Additional Comments and Recommendations

The agencies formalize a previous proposal to begin Stage 3 of Meaningful Use in 2017 in order to incorporate policy lessons from Stages 1 and 2.

RECOMMENDATION: CHIME supports the proposed 1-year extension of Stage 2 for providers that first became meaningful users in 2011 and 2012. We agree this is a necessary extension to give policymakers time to evaluate past experience and incorporate lessons learned into the third Stage of Meaningful Use.

CHIME once again appreciates the opportunity to provide comments on this proposed rule. If there are questions about CHIME's recommendations or more information is needed, please contact Jeffery Smith, Sr. Director of Federal Affairs, at jsmith@cio-chime.org or (703) 562-8876. We look forward to a continuing dialogue with your offices on this and other important matters.

Sincerely,

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