June 15, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Huber H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Modifications to Meaningful Use in 2015 through 2017 [RIN: 0938-AS58]

Dear Acting Administrator Slavitt,

On behalf of the American College of Physicians (ACP), I am writing to share our views on the Modifications to Meaningful Use (MU) in 2015 through 2017 proposed rule. ACP is the largest physician medical specialty society, and the second largest physician membership organization in the United States. ACP members include 141,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. The College thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on this proposed rule.

We applaud CMS for listening to and responding to our concerns about the difficulties our members are having in their attempts to achieve Stage 2 of MU. While the objectives were laudable, it became clear that some of the measures were unachievable by most physicians. We raised our concerns at every opportunity over the past three years, and we appreciate the way that CMS has responded in this proposed rule. Specifically, we find the following proposed changes to be especially helpful:

- Changing the reporting period to calendar year for all participants, replacing the current fiscal year reporting requirement for hospitals.
- Changing the reporting period for 2015 to any 90-day period.
• Changing the threshold from the Stage 2 Objective for Patient Electronic Access measure number 2 from "5 percent" to "equal to or greater than 1".
• Changing the threshold from the Stage 2 Objective Secure Electronic Messaging from being a percentage-based measure, to yes-no measure stating the "functionality fully enabled".
• Consolidating all public health reporting objectives into one objective with measure options following the structure of the Stage 3 Public Health Reporting Objective.

While it is clear that this proposed rule addresses many of our concerns, we believe that there are significant steps that CMA can take to further improve the EHR Incentive Program. We detail our suggestions in the following table, but here are the suggestions we feel are of greatest importance, and where further changes could have the greatest impact.

• We urge CMS and ONC to make the most of the opportunity presented by the Medicare Access and CHIP Reauthorization Act (MACRA) by postponing the start of Stage 3, reconsidering and reworking MU along with the other components of the new Merit-Based Incentive Payment System (MIPS), and by extending the proposed Stage 2 modifications, as revised, until the new comprehensive program is ready to be implemented.

• Overall, we support reporting of MU measures, taking into account the changes to those measures we are requested in our detailed comments to follow. Automated counters are not difficult or expensive for vendors to build/maintain; however, we do not support the use of thresholds. At this point in MU, the value of counting is not in measuring compliance to a threshold, but in supplying information to the learning healthcare system that to the MU program should be supporting. In that fashion, MU can leave a legacy of embedded and continuous learning, rather than an inflexible and overly prescriptive set of process measures.

• A major concern with the public reporting requirements (both public health and clinical reporting) is that, with the exception of immunizations, they are all one-way. Eligible Providers (EPs) and Eligible Hospitals (EHs) must collect and supply data to target agencies, but there is no requirement at all for these agencies to report back to the providers. The definition of “active engagement” must be expanded to require that all health data exchanges be bidirectional. Otherwise, these reporting measures demonstrate clerical data entry rather than meaningful use. Patients and their doctors will benefit greatly from requirements that public health agencies report back in a timely manner and with meaningful data, such as intelligence about what is happening in the community.
• Also, we are concerned that there is an expectation that public health reporting will require duplicative documentation into an electronic form, rather than the reporting system accepting the export of a Summary of Care Document (SoCD). All public health authorities must be compelled to coordinate and simplify reporting requirements or burden will not be decreased.

We ask that you will consider our comments, provided in the attached comment table, as you work to finalize this proposed rule. Should you have any questions, please contact Thomson Kuhn, Sr. Systems Architect, at tkuhn@acponline.org.

Sincerely,

Peter Basch, MD, MACP
Chair, Medical Informatics Committee
American College of Physicians
Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Modifications to Meaningful Use in 2015 through 2017

**Agency:** Centers for Medicare & Medicaid Services (CMS), HHS

**Action:** Proposed Rule

**COMMENTS DUE:** June 14, 2015

<table>
<thead>
<tr>
<th>Excerpts from the Modifications to MU in 2015 through 2017 Proposed Rule</th>
<th>Medical Informatics Committee Comments</th>
</tr>
</thead>
</table>
| **EHR Reporting Period in 2015 and 2016**  
We are proposing to align the definition of an EHR reporting period with the calendar year for all providers beginning in 2015 and continuing through 2016 onward. Specifically, this proposal would change the EHR reporting period for eligible hospitals and CAHs from a period based on the fiscal year to the calendar year beginning in 2015.  
For 2015 and 2016, we are proposing to allow new participants in the EHR Incentive Program to attest to meaningful use for an EHR reporting period of any continuous 90-day period within the calendar year. In addition, for 2015 only, we are proposing to allow all EPs (regardless of their prior participation in the program) to attest to an EHR reporting period of any continuous 90-day period within the calendar year.  
In 2016, we propose EPs, eligible hospitals, and CAHs that are demonstrating meaningful use for the first time may use an EHR reporting period of any continuous 90-day period between January 1, 2016 and December 31, 2016. However, all returning participants would use an EHR reporting period of a full calendar year from January 1, 2016 through December 31, 2016.  
We are proposing changes to individual objectives and measures for Stage 2 of meaningful use as follows:  
• Changing the threshold from the Stage 2 Objective for Patient Electronic Access | The 90-day reporting period for CY 2015 is much appreciated, and may help to bring many EPs back into the MU program.  
This threshold should be eliminated, as we really don’t know enough about which patients find their information useful, but reducing it to 1+ is also very much appreciated. Unlike ePrescribing, which held |
measure number 2 from "5 percent" to "equal to or greater than 1".

- Changing the threshold from the Stage 2 Objective Secure Electronic Messaging from being a percentage-based measure, to yes-no measure stating the "functionality fully enabled".
- Consolidating all public health reporting objectives into one objective with measure options following the structure of the Stage 3 Public Health Reporting Objective (80 FR 16745 through 16767).

Changing the measure for secure messaging to a yes/no attestation is also much appreciated. Again, having a capability for online communication with a provider’s office is a good thing to do, but thinking that every patient would find a compelling need to send a clinically relevant secure message for every provider, regardless of specialty was wrong. This will declare itself over time, and show marked differences by specialty.

Clinical Quality Measurement
We are not proposing changes to the CQM

Doctors responsible for patients’ acceptance of ePrescribing (and was successful), we were not responsible for making patients get a prescription when they didn’t need one, just to try ePrescribing. Experience in 2011 and 2012 showed that ePrescribing acceptance was gradual, and improved rapidly thereafter, not because of cajoling and gimmicks, but because it worked. Our message to patients, “give it a try...here’s a paper back up prescription in case you have a problem with trying ePrescribing,” was thus successful. Few patients gave up on ePrescribing, except where there was a reason not to use it, such as needing a paper prescription for price comparison-shopping. That strategy might work for patients who have data to view on the portal, but unlike the ePrescribing measure, a patient remains in the denominator even if one publishes no results to a portal. Further, even where information existed, it was not necessarily deemed valuable to patients, particularly if the results were only normal laboratory results. Patients should absolutely have an easy path to viewing their own information, either via a portal or some other vehicle, and for some patients, engagement with that information is very necessary to achieve good results, but it is not necessarily for everyone.

Aligning CQM reporting with MU reporting for 2015 is appreciated. The existing requirement
selection or reporting scheme (9 or 16 CQMs across at least 3 domains) from the CQM requirements previously established for all providers seeking to demonstrate meaningful use in the Medicare and Medicaid EHR Incentive Programs defined in earlier rulemaking (see, for example, 77 FR 54049 through 54089). For an EHR reporting period in 2015, and for providers demonstrating meaningful use for the first time in 2016, we are proposing that providers may—
• Attest to any continuous 90-day period of CQM data during the calendar year through the Medicare EHR Incentive Program registration and attestation site; or
• Electronically report CQM data using the established methods for electronic reporting.
For 2016 and subsequent years, providers beyond their first year of meaningful use may attest to one full calendar year of CQM data or they may electronically report their CQM data using the established methods for electronic reporting outlined in section II.C. of this proposed rule.

<table>
<thead>
<tr>
<th>Changes to Definitions for 2015 through 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this proposed rule to modify Stages 1 and 2 for meaningful use in 2015 through 2017, we propose to further reduce complexity in the program and work toward this overall shift to a single set of objectives and measures in Stage 3 in 2018. We propose to require all providers to attest to a single set of objectives and measures beginning with an EHR reporting period in 2015. These objectives and measures would leverage existing objectives and measures of meaningful use. Because this change may occur after providers have already begun their work toward meeting meaningful use in 2015, we propose accommodations within individual objectives for providers in 2016 and subsequent years.</td>
</tr>
</tbody>
</table>

Simplifying the program and reporting requirements is much appreciated. However, EPs just entering the program will be overwhelmed with the changes they must make to meet the high bar of the stage 3 requirements. For new participants there must be a simpler first year with an abbreviated reporting period.
different stages of meaningful use. These accommodations include retaining the different specifications between Stage 1 and Stage 2, and allowing special exclusions for certain objectives or measures for eligible providers previously scheduled to participate in Stage 1 for an EHR reporting period in 2015.

In this rule, we propose all providers would be required to attest to certain objectives and measures finalized in the Stage 2 final rule, which would align with those objectives and measures proposed for Stage 3 of meaningful use. In effect, this would create a new progression using the existing objectives and measures where providers attest to a modified version of Stage 2 with accommodations for Stage 1 providers (equivalent to a reduced version of Stage 3) in 2015; a modified version of Stage 2 in 2016 (equivalent to a reduced version of Stage 3); either a modified version of Stage 2 (equivalent to a reduced version of Stage 3) or the full version of Stage 3 outlined in the Stage 3 proposed rule in 2017; and the full version of Stage 3 outlined in the Stage 3 proposed rule beginning in 2018.

<table>
<thead>
<tr>
<th>This alignment of Stages 1 and 2 to the proposals for Stage 3 essentially creates a new paradigm for providers in 2015 through 2017. This includes a simplified structure and focus on the objectives and measures with sustainable growth potential aligned to the programs foundational goals prior to the full implementation of Stage 3 in 2018. This change could alleviate the need to include the option in 2017 to allow providers to choose to demonstrate Stage 3 of the program in 2017. To better understand the impact and potential complexity, we seek comment on whether or not we should implement only the modifications proposed in this rule from 2015 through 2017 and begin Stage 3 in 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regardless of the appropriateness of the Stage 3 measures, this approach of course correction and alignment towards Stage 3 is correct and appreciated.</td>
</tr>
<tr>
<td>There is no harm in allowing for optional reporting for Stage 3 in 2017, as long as this does not add significant complexity to CMS’s ability to receive reports from providers and hospitals. We do not believe that most vendors, practices, and CMS itself will be prepared for Stage 3 reporting in 2017.</td>
</tr>
<tr>
<td>We urge CMS and ONC to make the most of the opportunity presented by MACRA by postponing the start of Stage 3, reconsidering and reworking MU along with the other components of MIPS, and by extending the proposed Stage 2 modifications, as revised, until the new comprehensive program is ready to be implemented.</td>
</tr>
</tbody>
</table>
Without an option year in 2017, or if we should allow providers the option to demonstrate Stage 3 beginning in 2017 as discussed in the Stage 3 proposed rule (80 FR 16774). We seek comment on these proposals.

<table>
<thead>
<tr>
<th>Calendar Year Reporting Beginning in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning in 2015, we are proposing to change the definition of “EHR reporting period” at § 495.4 for EPs, eligible hospitals, and CAHs such that the EHR reporting period would begin and end in relation to a calendar year. This change would allow eligible hospitals and CAHs the same amount of time as EPs from the release of a new edition by ONC to the required date for full implementation of the EHR technology certified in accordance with those criteria. In this proposal, all providers (EPs, eligible hospitals, and CAHs) would be required to complete an EHR reporting period within January 1 and December 31 of the calendar year in order to demonstrate meaningful use. In order to accommodate eligible hospitals and CAHs that may have planned their EHR reporting period in 2015 during the federal fiscal year and want to continue to use that time period for reporting, we propose for 2015 only these providers may begin an EHR reporting period as early as October 1 of 2014 and end by December 31 of 2015. Beginning with 2016, the EHR reporting period must be completed within January 1 and December 31 of the calendar year. We seek comment on this proposal.</td>
</tr>
<tr>
<td>This change to the EHR reporting period makes sense and is appreciated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>90-day EHR Reporting Period for all Providers in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>For 2015 only, we are proposing to change the definition of &quot;EHR reporting period&quot; at § 495.4 for EPs, eligible hospitals, and CAHs such that the EHR reporting period in 2015 would be any continuous 90-day period within the</td>
</tr>
<tr>
<td>This is very much appreciated and does show that CMS and ONC have been responsive to legitimate concerns of certain stakeholders. A 90-day reporting period should also be specified for 2018 to allow EPs time to convert their systems and workflows for Stage 3, should the decision to start Stage 3 in 2018 be</td>
</tr>
</tbody>
</table>
calendar year. We intend this change to allow providers adequate time to plan for any necessary changes to their implementation of meaningful use required in order to accommodate the changes outlined in this proposed rule. We further believe this change is responsive to provider and stakeholder feedback received through correspondence, public forums, and public comment, which requested that we allow a 90-day EHR reporting period in 2015 in order to provide flexibility for continuing difficulties providers are experiencing with successful implementation of EHR technology certified to the 2014 Edition.

However, for all returning participants that have successfully demonstrated meaningful use in a prior year, the EHR reporting period would be a full calendar year from January 1, 2016 through December 31, 2016. In 2017, the EHR reporting period would be 1 full calendar year for all providers, as proposed in the Stage 3 proposed rule.

Considerations in Defining Meaningful Use
Our analysis of the objectives and measures of meaningful use Stages 1 and 2 identified a number of measures, which meet these criteria as either redundant, duplicative, or topped out with new participants consistently performing at a statistically comparable rate to returning participants. Table 3 identifies the current objectives and measures which meet these criteria. We are therefore proposing to no longer require providers to attest to these objectives and measures as currently codified in the CFR under § 495.6 in order to demonstrate meaningful use beginning in 2015.

<table>
<thead>
<tr>
<th>TABLE 3: OBJECTIVES AND MEASURES IDENTIFIED BY PROVIDER TYPE WHICH ARE REDUNDANT, DUPLICATIVE OR TOPPED OUT</th>
</tr>
</thead>
</table>

This logic is reasonable as is the expression that just because something is no longer required does not mean that providers should

We urge CMS and ONC to make the most of the opportunity presented by MACRA by postponing the start of Stage 3, reconsidering and reworking MU along with the other components of MIPS, and by extending the proposed Stage 2 modifications, as revised, until the new comprehensive program is ready to be implemented.

This logic is reasonable, but it is not applied consistently, as CPOE and ePrescribing both fit the definition of topped-out measures, but they are retained.
Objectives and Measures:  
Record Demographics  
Record Vital Signs  
Record Smoking Status  
Clinical Summaries  
Structured Lab Results  
Patient List  
Patient Reminders  
Summary of Care  
  Measure 1 – Any Method  
  Measure 3 – Test  
Electronic Notes  
Imaging Results  
Family Health History

We note that many of these objectives and measures include actions that may be valuable to providers and patients, such as providing a clinical summary to a patient after an office visit. We encourage providers to continue to conduct these activities as best suits their practice and the preferences of their patient population. The removal of these measures is in no way intended as a removal of endorsement of these best practices or to discourage providers from conducting and tracking these activities for their own quality improvement goal. Instead, we would no longer require providers to calculate and attest to the results of these measures in order to demonstrate meaningful use beginning in 2015. We seek comment on this proposal.

Changes to Definition of Meaningful Use for 2015 through 2017

Changes to Definition of Meaningful Use for 2015 through 2017  
While these changes are appreciated, the description of provider difficulty by CMS is stop doing something that is appropriate and relevant. Similar logic could and should be applied to other measures that were retained – as there is significant cost and complexity with the construction of every threshold measure with an automated counter.

MU functional measures were designed not only to change provider behavior, but also to create a market force for evolution in technological capabilities. Thus, the measure for structured lab results, which was not based on any actions of a provider but rather just the capability of having a lab interface into an EHR, was designed to create a market force for easy and inexpensive structured lab results (lab results interoperability). That did not produce the intended results, and the same costly interfaces prior to MU did not change with a 40% threshold, or a 55% threshold.

A major step forward in interoperability would occur if there were a way that CMS / ONC could require reference lab reporting to a certain specification, or via some other vehicle, such that lab reporting into EHRs would be free. For small practices that must interact with at least a handful of different labs, the current costs to interface are prohibitive. All labs need to use the same standards and terminologies as well as having standard interfaces for certified EHRs. EHR vendors should have a standardized interface to receive the structured data. The individual practice should not be required to provide the structure and pay someone to perform lab data entry into flow sheets.

By declaring this measure as “topped out,” CMS is declaring victory and walking away while the battle still rages in the trenches.
In addition, we have heard from stakeholder associations and provider representatives that providers have faced significant challenges in implementing the patient engagement objectives, which require patient action.

We recognize these concerns and are proposing changes to these objectives to allow providers to focus on improvements without jeopardizing their ability to successfully demonstrate meaningful use. These changes are outlined in section II.B.1.c.(2).(c). of this proposed rule.

<table>
<thead>
<tr>
<th>Structural Requirements of Meaningful Use in 2015 through 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>We propose to eliminate the distinction between core and menu objectives, and further propose that all retained objectives and measures would be required for the program. We note that for Stage 1 providers, this means three current menu objectives would now be required; and for Stage 2 eligible hospitals and CAHs, one current menu objective would now be a required objective. These objectives are as follows:</td>
</tr>
<tr>
<td>• Stage 1 Menu: Perform Medication Reconciliation</td>
</tr>
<tr>
<td>• Stage 1 Menu: Patient Specific Educational Resources</td>
</tr>
<tr>
<td>• Stage 1 Menu: Public Health Reporting Objectives (multiple options)</td>
</tr>
<tr>
<td>• Stage 2 Menu Eligible Hospitals and CAHs Only: Electronic Prescribing</td>
</tr>
</tbody>
</table>

We note that the objectives and measures retained in each case for all providers would be the Stage 2 objectives and measures; however, we are proposing to establish alternate exclusions and specifications to mitigate any additional burden on providers for an EHR reporting period in 2015.

Therefore, we propose that the structure of misleading. The issue is not an implementation challenge, but the fact that the measure is constructed to be dependent on patient actions. Many providers and organizations are increasingly relying on “gimmicks” (such as gift cards) to get patients to sign onto the portal once or to reply to a message.

These threshold requirements should be eliminated. (See our commentary on patient engagement and secure messaging below.)

This proposed change does make the program easier to understand and administer, particularly for practices and organizations that have providers in multiple stages of MU. It is also a logical reorganization of an approach to MU that transitions end-users to Stage 3, and allows for Stage 3 to be the only vehicle for MU in the future. However, we urge CMS and ONC to take their time to rethink the goals and objectives of Stage 3, now that it is part of MIPS. This modified rule should be in place at least through 2018, while Stage 3 is redesigned.
meaningful use for 2015 through 2017 would be 9 required objectives for EPs using the Stage 2 objectives for EPs with alternate exclusions and specifications for Stage 1 providers in 2015.

In addition, EPs would be required to report on a total of 2 measures from the public health reporting objective or meet the criteria for exclusion from up to 5 measures.

**Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use in 2015**

We are proposing several alternate exclusions and specifications for providers scheduled to demonstrate Stage 1 of meaningful use in 2015, which would allow these providers to continue to demonstrate meaningful use despite the proposals to use only the Stage 2 objectives and measures identified for meaningful use in 2015 through 2017.

We are proposing that for an EHR reporting period in 2015, providers scheduled to demonstrate Stage 1 of meaningful use may attest based on the specifications associated with the Stage 1 measure. We note that for an EHR reporting period beginning in 2016, all providers must attest to the specifications including the measure thresholds associated with the Stage 2 measure. For an EHR reporting period in 2016, all providers, including those who would otherwise be scheduled for Stage 1 in 2016, would be required to meet the Stage 2 specifications with no alternate exclusions.

For objectives where there is a measure that is not equivalent between Stage 1 and Stage 2 or where the objective moves from menu to core between Stage 1 and Stage 2, we propose to include an exclusion for providers who were scheduled to demonstrate Stage 1 of meaningful use for the EHR reporting period in

These alternate exclusions and specifications for Stage 1 providers for 2015 are reasonable.
2015. For example, Stage 1 providers may exclude from the requirement to send an electronic summary of care record for more than 10 percent of transitions of care as required in the Stage 2 Summary of Care objective measure 2.

<table>
<thead>
<tr>
<th>Changes to Patient Engagement Requirements for 2015 through 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers have indicated that while they support the goal of improved patient engagement, these issues are impacting their ability to meet the measure requirements.</td>
</tr>
</tbody>
</table>

We propose to modify these measures as follows:

- Patient Action to View, Download, or Transmit Health Information
- Remove the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access (VDT) objective. Instead require that at least 1 patient seen by the provider during the EHR reporting period views, downloads, or transmits his or her health information to a third party. This would demonstrate the capability is fully enabled and workflows to support the action have been established by the provider.
- Remove the 5 percent threshold for Measure 2 from the eligible hospital and CAH Stage 2 Patient Electronic Access (VDT) objective. Instead require that at least 1 patient discharged from the hospital during the EHR reporting period views, downloads, or transmits his or her health information to a third party. This would demonstrate the capability is fully enabled and workflows to support the action have been established by the provider.

We seek comment on potential alternate proposals for this proposed change to the threshold for Measure 2 of the Stage 2 Patient Electronic Access objective. For example, we seek comment on potential alternates such as

| The ACP believes that all healthcare providers have an obligation to provide patients with all of the data from their records that they wish to have. In addition, physicians have an obligation to go beyond simply providing raw data, by providing context and understanding to help patients make their data meaningful and actionable. Further, we believe that it is essential for physicians and other healthcare providers to attempt to adopt the communication preferences of their patients as best they are able. Physicians need systems that allow them the flexibility they need to accommodate these preferences. They do not need one-size-fits-all mandates from CMS. |

We appreciate the responsiveness of CMS and ONC to stakeholder concerns regarding threshold measures where providers are held responsible for patient actions. Reasons for provider concerns include:

1. The denominator applies to all patients seen and not just to patients who have a reason to go to a portal or similar vehicle to view new results.
2. The denominator applies to all patients seen and not just patients with chronic diseases, where those chronic diseases are followed with lab results.

There is an assumption by CMS that “engagement with data” is generally desired by patients. This is not the case. For otherwise healthy patients seeing a specialist or having a procedure done, there is absolutely no interest in logging in to yet another patient portal to review a result that they already
a percentage threshold less than 5 percent, or a numerator greater than 10 patients, or another similar numerical alternative. We further seek comment on suggestions for other potential alternatives which would accomplish the goals here stated of reducing the burden on providers to account for patient actions while still continuing to encourage IT supported patient engagement.

● Secure Electronic Messaging Using CEHRT ++ Convert the measure for the Stage 2 EP Secure Electronic Messaging objective from the 5 percent threshold to a yes/no attestation to the statement: "The capability for patients to send and receive a secure electronic message was enabled during the EHR reporting period".

We note that these changes are intended to allow providers to work toward meaningful patient engagement through health IT using the methods best suited to their practice and their patient population. We further note that the Stage 3 proposed rule includes an objective exclusively focused on patient engagement with an expanded set of measures and increased thresholds which providers would be required to meet beginning in 2018 (and optionally in 2017). We invite public comment on this proposal.

While we are 100% behind the ability of patients to more easily get their information in a timely fashion, we believe there is a distinction between making something readily available, and assuming that availability alone suffices a compelling reason to view, access, or transmit their information.

In fact, providers and provider organizations have been making portals or other electronic access available since 2001, and, with some exceptions, many have noticed that uptick has been uneven at best. This is thus a field ripe for further study; and in fact, ONC is attempting to better understand this issue. A major reason why acceptance has been so low, even among patients who could genuinely benefit, is that the quality of many, possibly most, existing patient portals can fairly be described as terrible. By these measures, CMS is attempting to force patients to interact with unusable systems.

Many practices have been making sincere and ongoing attempts to sell the portal to their patients. Some provider organizations are increasingly relying on “gimmicks” (such as gift cards) to get patients to sign onto the portal once or to reply to a message. There are clearly populations of patients who do not want to interact electronically with their information. They want to talk with their doctors and other clinicians, either in person or on the phone. Many other patients are suffering from “portal fatigue,” a condition caused by every doctor they see trying to convince them to log into that portal to see information that they already know.

CMS has taken away the ability of doctors to let patients choose their preferred methods of communication. Any evidence of positive
effects of portal use is contaminated by the obvious fact that already engaged patients are more likely to use portals.

Currently, most portals contain little more than facts – demographics, lists of problems, medications, test results, etc. There is no context provided to help patients understand what they are looking at. Context is needed for data to be meaningful and actionable to the patient. At least until the doctor’s notes are included in the portal, and even after then, doctors will have to supply the context via traditional means.

Assuming having an automated counter is not onerous to build, it would be interesting and useful for ONC and CMS to consider requiring reporting on this measure without having a threshold. In that fashion, CMS and ONC could learn more about what type of patients, and for what specialists, are more interested in access to their data, how often they use it, whether they find it useful, and if it improves outcomes.

Regarding secure messaging from patients, we suggest the same approach as above. Assuming having an automated counter is not onerous to build, it would be interesting and useful to ONC and CMS to consider requiring reporting on this measure without having a threshold. In that fashion, CMS and ONC could learn more about what type of patients, and for what specialists, are more interested in using secure messaging, and what impact that has on quality, satisfaction, and perhaps other measures.

<table>
<thead>
<tr>
<th>Meaningful Use Objectives and Measures for 2015, 2016, and 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proposed Objective:</strong> Protect electronic health information created or maintained by the CEHRT through the implementation of</td>
</tr>
</tbody>
</table>
| Clinical Decision Support | Proposed Measure: In order for EPs, eligible hospitals, and CAHs to meet the objective they must satisfy both of the following measures:  
- Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.  
- Measure 2: The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.  
For the first measure, it is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency.  
Exclusion: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.  
Measure 1: CDS should be taken very seriously by providers, and specifying a minimum number of CDS interventions regardless of specialty is a mistake. While the statement that providers should select their CDS as supportive of CQMs is correct; where there are not sufficient relevant CQMs, to require CDS interventions that support high-priority health conditions is not appropriate. What will a dermatologist learn about EHRs and CDS if what they see are prompts or forms that support hypertension control or mammography screenings? They will of course learn to ignore CDS interventions, as they are not relevant to their practice. Practices should focus on high-priority health conditions relevant to the practice’s population of patients. This could be done better in a continuous quality improvement fashion,  
Measure 2: It is now abundantly clear that the major source of alert fatigue is drug-drug, drug-allergy warnings. This requirement sends a message to providers that although there is evidence of this approach leading to |
| Proposed Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process. | This is an important aspect of ensuring the security of private health data. ONC and CMS should offer a free toolkit, or other educational materials, for providers in solo and small practice, and also regularly survey providers as to the cost of meeting this measure. If ONC and CMS do not take responsibility for providing complete guidance for small practices, the cost of this annual review can be unaffordable. |
inundation of irrelevant warnings and errors due to alert fatigue, the program refuses to amend itself in order to accommodate users. However, if this were required, and ONC concurrently commissioned a body of work to support improving the current process, and made use of provider overrides to help make the alerting process more effective, that could be useful.

**Computerized Provider Order Entry (CPOE)**

We are proposing to retain the Stage 2 objective and measures for Computerized Provider Order Entry (CPOE) for meaningful use in 2015 through 2017, with the modifications proposed here as alternate exclusions and specifications for Stage 1 providers for an EHR reporting period in 2015.

**Proposed Measures:** In Stage 2 of meaningful use, we adopted three measures for this objective:

- **Measure 1:** More than 60 percent of medication orders created by the EP or by 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 computerized provider order entry.
- **Measure 2:** More than 30 percent of laboratory orders created by the EP or by 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 computerized provider order entry.
- **Measure 3:** More than 30 percent of radiology orders created by the EP or by 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 computerized provider order entry.

In an effort to respond to this safely and widely used workflow, the measure was released not as some commenters suggested – which was to redefine CPOE as either ‘computerized provider order entry’ or ‘computerized provider order evaluation’ – where evaluation occurred prior to an order being acted upon, and also required the provider to view all actionable alerts. Rather, the definition of provider was extended to any licensed or certified healthcare professional, which includes almost anyone in a provider’s office who might be entering orders (with the exception of non-clinical staff). While this was appreciated in the Stage 2 FR as a reasonable accommodation – as CPOE is also a “topped-out” measure per CMS, and whatever evidence exists for the benefit of CPOE does not include CPOE done by medical assistants, it begs the question as to why CPOE needs to continue as a threshold measure.

Further, whatever evidence exists for the benefit of CPOE was not developed with CPOE done by CMAs – and CMAs were added to the definition of licensed healthcare professionals because without their inclusion, outpatient workflow would be significantly impacted.

As mentioned above, as the measure is already topped out, and providers are responsible for what they order already, why not collect the data without requiring a threshold. In this fashion, ONC and CMS can learn more about the effectiveness of CPOE in...
We propose to retain the three measures of this current Stage 2 objective to calculate a percentage threshold for all three types of orders: medication, laboratory, and radiology. We propose to retain exclusionary criteria for those providers who so infrequently issue an order type that it is not practical to implement CPOE for that order type. To calculate the percentage, CMS and ONC have worked together to define the following for this objective:

**Measure 1:**
Denominator: Number of medication orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.
Numerator: The number of orders in the denominator recorded using CPOE.
Threshold: The resulting percentage must be more than 60 percent in order for an EP, eligible hospital or CAH to meet this measure.
Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

**Measure 2:**
Denominator: Number of laboratory orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.
Numerator: The number of orders in the denominator recorded using CPOE.
Threshold: The resulting percentage must be more than 30 percent in order for an EP, eligible hospital or CAH to meet this measure.
Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

**Measure 3:**

As mentioned above, as the measure is already topped out, and providers are responsible for what they order already, why not collect the data without requiring a threshold. In this fashion, ONC and CMS can learn more about the effectiveness of CPOE in different settings, and done by professionals at different levels of training.
<table>
<thead>
<tr>
<th>Denominator: Number of radiology orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. Numerator: The number of orders in the denominator recorded using CPOE. Threshold: The resulting percentage must be more than 30 percent in order for an EP, eligible hospital or CAH to meet this measure. Exclusion: Any EP who writes fewer than 100 radiology orders during the EHR reporting period. An EP through a combination of meeting the thresholds and exclusions (or both) must satisfy all three measures for this objective. A hospital must meet the thresholds for all three measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use in 2015</strong> We propose that providers who are scheduled to demonstrate Stage 1 of meaningful use for an EHR reporting period in 2015 may attest to meaningful use using the specifications and thresholds established for the Stage 1 objectives and measures as they are currently defined at 42 CFR 495.6 for each retained objective or measure where there is a difference in specifications between Stages 1 and 2. We further propose that providers scheduled to demonstrate Stage 1 of meaningful use for an EHR reporting period in 2015 may claim an exclusion for any retained Stage 2 measure where there is not an equivalent Stage 1 measure currently defined at 42 CFR 495.6. The Stage 2 CPOE objective includes measures for laboratory and radiology orders, whereas the Stage 1 CPOE objective does not include these measures. Thus, we propose that for an EHR reporting period in 2015 only, providers scheduled to demonstrate Stage 1 of meaningful use in...</td>
</tr>
<tr>
<td>This alternate exclusion for Stage 1 in 2015 is helpful and appreciated.</td>
</tr>
</tbody>
</table>
2015 may exclude the Stage 2 CPOE measures for laboratory and radiology orders (measures 2 and 3 listed previously). We propose that for an EHR reporting period beginning in 2016, all providers must attest to the Stage 2 objective and measures, and meet the thresholds associated with all three of the Stage 2 measures discussed previously in order to successfully demonstrate meaningful use.

**Alternate Measure 1:** More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30 percent of medication orders created by the EP during the EHR reporting period, or created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry.

**Alternate Exclusion for Measure 2:** Provider may claim an exclusion for measure (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

**Alternate Exclusion for Measure 3:** Provider may claim an exclusion for measure (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.

We invite public comment on this proposal.

**Electronic Prescribing**

We are proposing to retain the Stage 2 objective and measure for Electronic Prescribing (eRx) for EPs as well as for eligible hospitals and CAHs for meaningful use in 2015 through 2017. EPrescribing more than meets the definition of a "topped out" measure, and could be retired. The mean rate of ePrescribing by those who have attested to meaningful use is greater than 90%. If CMS would like to see a threshold closer to 100%, it should mandate
**Proposed EP Measure:** More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using Certified EHR Technology.

To calculate the percentage, CMS and ONC have worked together to define the following for this objective:

- **Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.
- **Numerator:** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.
- **Threshold:** The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- **Exclusions:** Any EP who:
  - Writes fewer than 100 permissible prescriptions during the EHR reporting period; or
  - Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his or her EHR reporting period.

**Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use in 2015**

We are proposing that for an EHR reporting period in 2015, EPs scheduled to demonstrate Stage 1 of meaningful use may attest to the specifications and threshold associated with the Stage 1 measure. We note that for an EHR reporting period beginning in 2016, all EPs must meet the

This alternative exclusion for Stage 1 in 2015 is useful and appreciated.
specifications and threshold for the retained Stage 2 measure in order to successfully demonstrate meaningful use.

Alternate EP Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using Certified EHR Technology.

There are no alternate exclusions for this EP objective.

<table>
<thead>
<tr>
<th>Summary of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are proposing to retain only the second measure of the existing Stage 2 objective for Summary of Care for meaningful use in 2015 through 2017 with the modifications discussed in this proposed rule.</td>
</tr>
</tbody>
</table>

| Proposed Measure: | This is acceptable, but with certain caveats. The definition of care transitions is difficult to understand and apply a technology to, particularly when these transitions occur in settings where providers don’t actually make a referral. Further, because the person referred to is often not the person seen, forcing a choice of who to send information to before the appointment is made often results in a transition being sent to wrong person. |
| The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care that -- (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals. | The electronic sending and receiving of summaries of care remains extremely difficult for small private practices who do not have access to HIE networks and by definition are not part of large health systems. This is true for small private primary care offices as well as small private specialist offices. Summaries of care are still frequently done by faxing in these situations. |

The proposed updates to this measure reflect stakeholder input regarding operational challenges in meeting this measure, and seek to increase flexibility for providers while continuing to drive interoperability across care settings and encouraging further innovation. Currently, the measure specifies the manner in which the summary of care must be electronically transmitted. Providers must either-- (1) electronically transmit the summary of care using CEHRT to a recipient; or (2) where the recipient receives the summary of care record via exchange

<table>
<thead>
<tr>
<th>What could help to make this better?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• As there will always be confusion as to what actually works, we recommend removing the threshold on this measure. Then the lack of clarity as to exactly how this is counted becomes less important.</td>
</tr>
<tr>
<td>• Develop multiple approaches as options for providers for transmission of key information – to account for how referrals and transitions actually occur – including keeping the existing path of DIRECT.</td>
</tr>
</tbody>
</table>
facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. We propose to update this measure to state simply that a provider would be required to create the summary of care record using CEHRT and transmit the summary of care record electronically.

To calculate the percentage of the measure, CMS and ONC have worked together to define the following for this objective:

Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using Certified EHR Technology and is exchanged electronically.

Threshold: The percentage must be more than 10 percent in order for an EP, eligible hospital or CAH to meet this measure.

Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

- ONC should help to build a provider, ED, hospital directory, and further help to monitor and allow changes to this approach, reflecting what appears to be working – rather than locking in a highly prescriptive mechanism based on vision in 2015 of “transitions of care.”

Thus, while it is appreciated that the measure is simplified to account only for transmission, and not proposing that the measure be further complicated by making EHRs and providers responsible for (1) receipt and (2) follow-up regarding usefulness, we will otherwise just squander the opportunity of 2015-2017 by just counting what can easily be counted, instead of leveraging the opportunity to see what might actually work.

**Patient Specific Education**

We are proposing to retain the Stage 2 objective and measure for Patient Specific Education for meaningful use for 2015 through 2017.

Proposed EP Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

As it stands, most providers will be able to find a workaround to satisfy this measure, and typically many are doing so, by automating education based on some trigger in the EHR. However, the measure denominator is flawed because it is based on patients seen, rather than patients needing specific educational materials, such as all patients with a new medication, all patients with a new diagnosis, all patients who are unable to meet a clinical goal, etc.
To calculate the percentage for EPs, CMS and ONC have worked together to define the following for this objective:

**Denominator:** Number of unique patients with office visits seen by the EP during the EHR reporting period.

**Numerator:** Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology.

**Threshold:** The resulting percentage must be more than 10 percent in order for an EP to meet this measure.

**Exclusion:** Any EP who has no office visits during the EHR reporting period.

We are seeing redundant obligatory basic patient education given to a patient repeatedly at each encounter. We are using more paper than ever before. Some may be useful and relevant, but most goes directly into the trashcan at home or in the parking lot outside the practice.

Again, a more useful approach would be to encourage different approaches, and collecting information over the next few years to see what is most effective for patients, rather than keeping this an automated checkbox function. This requires a substitution of thoughtfulness with boilerplate logic, as that would be the only way to guarantee compliance with the threshold.

<table>
<thead>
<tr>
<th>Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternate Exclusion:</strong> Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective. There are no alternate specifications for this objective. We invite public comment on this proposal.</td>
</tr>
<tr>
<td>It is appreciated to keep with the format of allowing for 2015 Stage 1 alternate exclusions, although less necessary than other alternate exclusions that we support in this rule.</td>
</tr>
</tbody>
</table>

**Medication Reconciliation**

We are proposing to retain the Stage 2 objective and measure for Medication.

**Proposed Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

To calculate the percentage, CMS and ONC have worked together to define the following for this objective:

What has made this measure problematic for providers from the beginning has not been the numerator requirement, but the denominator definition. Determining what constitutes a transition visit is often more difficult than performing the reconciliation. Essentially the question to the patient that currently exists is, “since your last visit to me, have you seen another physician or been to an ED, hospital, or other facility and not already seen someone else in my practice / health system?” When providers ask that question it often leads to
Denominator: Number of transitions of care during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.

Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.

Threshold: The resulting percentage must be more than 50 percent in order for an EP, eligible hospital or CAH to meet this measure.

Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

At least in primary care, we understand that every time we review and reconcile medications after a visit, there are any number of things that regularly happen even in the absence of seeing another provider, that has led us to believe that a medication review and reconciliation with each visit is a best practice. To primary care providers, every visit is a transition, as when the patient is home, they uncover old pill bottles, get renewals (or not) which may appear different, leading to some patients taking multiple versions of the same medication. We would rather have the measure reflect reality, and not demand a manual denominator trigger to reflect inaccurate reasoning. We are available to work with CMS to get this denominator right.

**Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use in 2015**

Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.

There are no alternate specifications for this objective. We invite public comment on this proposal.

**Patient Electronic Access (VDT)**

We are proposing to retain the Stage 2 objective for Patient Electronic Access for meaningful use in 2015 through 2017. We are proposing to retain the first measure of the Stage 2 objective without modification. We

It is appreciated to keep with the format of allowing for 2015 Stage 1 alternate exclusions, although less necessary than other alternate exclusions that we support in this rule.
are proposing to retain the second measure for the Stage 2 objective with modification to the measure threshold.

**Proposed EP Measures:**
- **EP Measure 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information.
- **EP Measure 2:** At least one patient seen by the EP during the EHR reporting period (or their authorized representatives) views, downloads, or transmits his or her health information to a third party.

In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:

++ Patient name.
++ Provider's name and office contact information.
++ Current and past problem list.
++ Procedures.
++ Laboratory test results.
++ Current medication list and medication history.
++ Current medication allergy list and medication allergy history.
++ Vital signs (height, weight, blood pressure, BMI, growth charts).
++ Smoking status.
++ Demographic information (preferred language, sex, race, ethnicity, date of birth).
++ Care plan field(s), including goals and instructions.
++ Any known care team members including the primary care provider (PCP) of record.

Measure 1 is an overly complex measure with two parts to the numerator, which is extremely difficult to understand or use consistently. The measure calls for both a static numerator count of 50%+ of patients seen and a dynamic numerator count of patients who also have access to their “information” within 4 business days. As the number of times that “information” is available to a patient is more than once during a measure period, how then is a patient counted in the numerator? Is it if they have access to information within 4 business days once within the measure period, or only if each instance of information availability is within 4 business days during the measure period? This needs to be corrected. CMS needs to state precisely if the measure is looking at once per patient during the period.

For Measure 2, the definition of what must be available is confusing and sounds much more like what is being measured is a C-CDA after a visit, rather than results, as the definition includes all of the fields of a summary of care record. If indeed that is the case, the definition of what must be available to the patient is a C-CDA wrapper for every result, and not just the result. This is nonsensical. Please review the verbatim description in the left column of what fields must be supplied to patients within 4 business days of that information being available to the EP.

Overall, we question the usefulness of this for patients. Patients are often unable to actually find the results they were looking for. Further, the result is not attached to a reading or interpretation, so unless a second and non-
required step is done, the patient ends up with online clutter, perhaps not the result they were looking for, and certainly no interpretation or next steps. Alternatively, the patient gets their results and a C-CDA wrapper of 6-10 pages that serves to make the results less obvious.

<p>| ● EP Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. | This exclusion is insufficient, as it does not exclude EPs who do not order tests. A provider is included if all he/she does is prescribe a medication, or list an OTC medication that the patient states he/she is taking. Those are not compelling reasons to expect a patient would want to view his/her information online. |
| Denominator: Number of unique patients seen by the EP during the EHR reporting period. | ● Exclusions: Any EP who-- (a) Neither orders nor creates any of the information listed for inclusion as part of the measures; or (b) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. |
| Numerator: The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information. | It is appreciated to keep with the format of Alternate Exclusions and Specifications for | |
| Threshold: The resulting percentage must be more than 50 percent in order for an EP to meet this measure. |</p>
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1 Providers for Meaningful Use in 2015</strong></td>
<td>● Alternate Exclusion Measure 2: Provider may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure. There are no alternate specifications for this objective. We invite public comment on this proposal. allowing for 2015 Stage 1 alternate exclusions.</td>
</tr>
<tr>
<td><strong>Secure Electronic Messaging</strong></td>
<td>We are proposing to retain the Stage 2 objective for secure electronic messaging with modifications to the measure for meaningful use in 2015 through 2017. Proposed Measure: During the EHR reporting period, the capability for patients to send and receive a secure electronic message with the provider was fully enabled. We propose to retain the exclusion for EPs who have no office visits, and for those EPs who lack the infrastructure required for secure electronic messaging due to being located in areas with limited broadband availability as identified by the FCC. Exclusion: Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. As mentioned before, this is another good opportunity to test an approach for Stage 3, which is to require an attestation of capability, and the reporting of data for that measure, and not require a threshold. Different types of patients and more importantly, patients seeing providers in different specialties, are more or less likely to send secure messages. Seeing a specialist for a simple consult or procedure is not going to generate interest in most patients or doctors in sending a follow-up message.</td>
</tr>
<tr>
<td><strong>Public Health and Clinical Data Registry (CDR) Reporting</strong></td>
<td>As mentioned previously, we are proposing to adopt the consolidated Stage 3 version of the public health reporting objectives for all providers to demonstrate meaningful use for an EHR reporting period in 2015 through 2017. A major concern with these reporting requirements is that they are all one-way. EPs and EHs must collect and supply data to target agencies, but there is no requirement at all for these agencies to report back to the providers. The definition of “active engagement” must be expanded to require that all health data exchanges be bidirectional. Otherwise, these</td>
</tr>
</tbody>
</table>
For purposes of meeting this new objective, EPs, eligible hospitals and CAHs would be required to demonstrate that "active engagement" with a PHA or CDR has occurred. Active engagement means that the provider is in the process of moving towards sending "production data" to a PHA or CDR, or— is sending production data to a PHA or CDR. We note that the term "production data" refers to data generated through clinical processes involving patient care, and it is here used to distinguish between this data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers. We propose that "active engagement" may be demonstrated by any of the following options:

**Active Engagement Option 1—Completed Registration to Submit Data:** The EP, eligible hospital, or CAH registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP, eligible hospital, or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation.

**Active Engagement Option 2 - Testing and Validation:** The EP, eligible hospital, or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

**Active Engagement Option 3 – Production:** The EP, eligible hospital, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

reporting measures demonstrate clerical data entry rather than meaningful use. Patients and their doctors will benefit greatly from requirements that public health agencies report back in a timely manner and with meaningful data, such as intelligence about what is happening in the community.

EPs and hospitals are required to engage with all of the PHAs and CDRs in their service area, which often includes several states and other jurisdictions. Unless public authorities are compelled to coordinate and simplify requirements, providers are guaranteed undue complexity and expense. As is already known from prior stages of MU, having a requirement that providers connect to disparate registries has not created a market force for registries to accept the output from EHRs. The proposed immunization reporting measure requires bidirectional exchange. All reporting measures should require the same.

This requirement does not deal with the lack of registry readiness in certain areas to accept data. Again, the onus is on EPs to connect, or regularly check the central repository, rather than additionally creating a utility to which providers can send production data, and it is the local registries concern to connect to that hub.
Proposed Measures: We are proposing a total of 6 possible measures for this objective. For meaningful use in 2015 through 2017, EPs would be required to choose from Measures 1 through 5, and would be required to successfully attest to any combination of two measures.

Measures for Objective 8 – Public Health and Clinical Data Registry Reporting Objective

Measure
Measure 1 – Immunization Registry Reporting
Measure 2 – Syndromic Surveillance Reporting
Measure 3 – Case Reporting
Measure 4 - Public Health Registry Reporting*
Measure 5 - Clinical Data Registry Reporting**

● Measure 1 – 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).

Exclusion: Any EP, eligible hospital, or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP, eligible hospital, or CAH:
++ Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;
++ Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR

This measure makes sense, and would be more useful if it also were paired with a requirement of states to manage the output of CEHRT, such that providers did not have to purchase multiple interfaces based on state-by-state variability.

Immunization registries still have unique and nonstandard requirements. EHRs must not be required to accommodate all of them. There is a responsibility on IIS’ to update their systems to a single standard.

We fully support bidirectional exchange of immunization data. CMS should require that all health data exchanges and reporting measures be bidirectional. Otherwise, these reporting measures demonstrate clerical data entry rather than meaningful use. Patients and their doctors will benefit greatly from requirements that public health agencies report back in a timely manner and with meaningful data.

We are concerned that there is an expectation that public health reporting will require duplicative documentation into an electronic form, rather than the reporting system accepting the export of an SoCD? All public health authorities must be compelled to coordinate and simplify reporting
reporting period; or
++ Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP, eligible hospital or CAHs at the start of the EHR reporting period.

<table>
<thead>
<tr>
<th>Measure 2–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).</th>
</tr>
</thead>
</table>
| **Exclusion for EPs:** Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—
  ++ Does not treat or diagnose or directly treat any disease or condition associated with a syndromic surveillance system in his or her jurisdiction;
  ++ Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  ++ Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. |
| We are not aware of registries being ready to accept syndromic surveillance reporting from EPs. This is not really an option and should be excluded. EPs and EHS must collect and supply data to target agencies, but there is no requirement at all for these agencies to report back to the providers. The definition of “active engagement” must be expanded to require that all health data exchanges be bidirectional. Otherwise, these reporting measures demonstrate clerical data entry rather than meaningful use. Patients and their doctors will benefit greatly from requirements that public health agencies report back in a timely manner and with meaningful data. The proposed immunization reporting measure requires bidirectional exchange. All reporting measures should require the same. |
| Measure 3–Case Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. This is a new reporting option that was not part of Stage 2. The collection of electronic data is required. |
| There is no available standard for this reporting activity. This places EPs at the mercy of the receiving authorities who can specify whatever format, data, and reporting requirements they choose. The standard that ONC has proposed will not be available to any health agency. |
case reporting data greatly improves reporting efficiencies between providers and the PHA. Public health agencies collect "reportable conditions" as defined by the state, territorial, and local PHAs to monitor disease trends and support the management of outbreaks. In many circumstances, there has been low reporting compliance because providers do not know when, where, or how to report. In some cases, the time burden to report can also contribute to low reporting compliance.

**To support case reporting, the ONC has proposed a certification criterion that includes capabilities to enable certified EHR systems to send initial case reporting data and receive a request from the public health agency for supplemental or ad hoc structured data in the 2015 Edition proposed rule** (80 FR 16855).

**Exclusion:** Any EP, eligible hospital, or CAH meeting one or more of the following criteria may be excluded from the case reporting measure if the EP, eligible hospital, or CAH:

++ Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period;
++ Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
++ Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data at the start of the EHR reporting period.

<table>
<thead>
<tr>
<th>Measure 4 - 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are concerned that there is an expectation that public health reporting will require duplicative documentation into an electronic form, rather than the reporting system accepting the export of an SoCD. All public health authorities must be compelled to coordinate and simplify reporting requirements or burden will not be decreased. Development by PHAs of such additional queries should be based on use of structured data that already exists, and not requiring duplicative documentation or documentation irrelevant for patient care. Note that functionality to support additional queries does not yet exist, so it may not really be an option for 2017. Since the proposed standard is still a long way from actual publication, we must assume that it will not be ready for vendor implementation in time for certification. Unlike some standards, a great deal of new functionality must be developed by the vendors to support this sort of query.</td>
</tr>
</tbody>
</table>
In response to insight gained from the industry through listening sessions, public forums, and responses to a Federal Register notice soliciting public comments on the proposed information collections to develop a centralized repository on public health readiness to support meaningful use (79 FR 7461); we propose to carry forward the concept behind this broad category from Stage 2, but also propose to split public health registry reporting from clinical data registry reporting into two separate measures which better define the potential types of registries available for reporting. We propose to define a "public health registry" as a registry that is administered by, or on behalf of, a local, state, territorial, or national PHA and which collects data for public health purposes.

**Exclusions:** Any EP, eligible hospital, or CAH meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP, eligible hospital, or CAH—

++ Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period;  
++ Operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or  
++ Operates in a jurisdiction where no public health registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

**Measure 5—Clinical Data Registry Reporting:**  
The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry. Clinical data registries do exist, and all come with an additional cost to providers. Are clinical data registries required to accept the
For Stage 3, we propose to include clinical data registry reporting as an independent measure. The National Quality Registry Network defines clinical data registries as those that record information about the health status of patients and the health care they receive over varying periods of time.

**Exclusion:** Any EP, eligible hospital, or CAH meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure if the EP, eligible hospital, or CAH—

++ Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period;
++ Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
++ Operates in a jurisdiction where no clinical data registry for which the EP, eligible hospital, or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

output of a CEHRT? If that is not the case, this requirement may be forcing a behavior upon which providers have no leverage in terms of cost.

All public health registries must be brought into full compatibility by 2018. It is unacceptable for physicians to have to pay vendors to support all of the registries for all of the states. It will be far less expensive to the health care system for all public registries to achieve full compatibility in accepting reports.