December 15, 2015

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

Ref: 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:

America’s Essential Hospitals appreciates the opportunity to submit these comments in response to the above-captioned final rules. We support the Centers for Medicare & Medicaid Services’ (CMS’) aim to encourage the advanced use of electronic health records (EHRs) by eligible hospitals (EHs) and eligible professionals (EPs) through the Medicare and Medicaid EHR Incentive Programs (meaningful use program). EHRs should be used to help providers improve the care they deliver to patients without overburdening their systems and infrastructures. However, we are concerned that provisions of the final rules fall short of these aspirations in many ways.

America’s Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our roughly 275 member hospitals provide a disproportionate share of the nation’s uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of patients at essential hospitals are racial and ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital field—an
aggregate operating margin of negative 3.2 percent, compared with positive 5.7 percent for all hospitals nationwide.¹

The commitment essential hospitals make to serve all people, regardless of income or insurance status, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing electronic patient information, including poverty, homelessness, language barriers, and low health literacy.

We are concerned that some aspects of the final rule impose unnecessary burdens on providers instead of incorporating meaningful metrics that facilitate the provision of health care and improve the provider-patient relationship. The Stage 3 provisions of the final rule merely build on many flawed elements of the existing program, simply raising thresholds for measures already demonstrated to be unfeasible to achieve. The requirements of the meaningful use program so far have proved quite onerous for providers, particularly essential hospitals with scarce resources and diverse patient populations. Without requisite advances—truly interoperable products, standards that ensure the seamless exchange and use of health information, and adequate testing of these standards and of electronic clinical quality measures, for example—CMS should not rush providers into Stage 3.

America’s Essential Hospitals commends the agency for some of the flexibility it provided by modifying the requirements of the program for the 2015 through 2017 reporting years. The great majority of essential hospitals have implemented EHR systems in their integrated health systems and become meaningful users of this technology. However, the association remains concerned that as CMS moves forward with its plans for Stage 3 of the program, some essential providers continue to experience difficulty with the program’s current structure, both in terms of their infrastructure and their diverse patient populations. Furthermore, substantial developments in the national health information technology (IT) infrastructure are necessary before all providers can achieve objectives requiring advanced functionalities, such as health information exchange. While modifications to the meaningful use program were a crucial first step, we believe CMS should not have finalized the Stage 3 proposals until providers, vendors, and other stakeholders were equipped with the tools necessary for achieving the agency’s aspirational goals for the advanced use of EHRs. To ease the transition to Stages 2 and 3, CMS should consider changes to meaningful use that will reduce the burden on providers, offer them much-needed flexibility, and

afford public and private stakeholders the time to make improvements in interoperability.

Many hospitals already have started receiving penalties for not participating in the meaningful use program and others are no longer receiving Medicare incentive payments, which will cease for all hospitals after 2016. These circumstances compound essential hospitals’ challenges and call for much-needed accommodations to ensure they are not unfairly disadvantaged for serving vulnerable populations and can continue to provide vital services to their communities.

We urge the agency to make desperately needed changes to the meaningful use program that will reduce the burden on providers in the interim and give stakeholders time to take vital steps toward achieving the next phase of EHR use—one that achieves interoperability and improves the provider-patient experience.

1. **CMS should offer accommodations for providers who are unable to achieve meaningful use in 2015 due to the delay in finalizing the rule.**

**CMS should allow for flexibility in 2015 reporting so that providers may receive incentive payments and are not penalized for being unable to attest to meaningful use for reasons stemming from the delay in the issuance of the final rule.** The modifications rule makes several changes to the meaningful use timeline for EHs beginning in 2015. For example, it shifts EHs to a calendar year (CY) reporting schedule in 2015, instead of a fiscal year. The rule also finalizes a reporting period of 90 days in 2015 to fall between October 1, 2014, and December 31, 2015, for EHs. To complete a continuous 90-day reporting period by December 31, an EH would have had to begin its reporting period no later than October 2, 2015. However, the rule was finalized after this date, leaving providers with substantial uncertainty on the requirements of the program. **For those providers who were unable to attest in time because of the delay in finalizing this rule, CMS should provide additional time by extending the reporting period into 2016 and offering hardship exceptions to providers adversely affected by the final rule’s delay.**

CMS has noted in subregulatory guidance that it will accept applications for hardship exceptions for providers who were affected by the delay in the rule.² America’s Essential Hospitals appreciates this flexibility CMS offers, and we strongly encourage CMS to grant these hardship exceptions when the final rule delay caused the attestation delay. However, while providers can avoid negative payment adjustments by submitting a hardship exception, they may forgo

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incentive payments if they are unable to complete their 90-day reporting period. Medicare incentive payments continue through 2016, and providers may receive Medicaid incentive payments from states beyond 2016. Some providers are willing and able to attest in 2015, but may have been delayed by only a few days in beginning their reporting period. To allow these providers to complete their reporting periods and attest to meaningful use, CMS should consider extending the 2015 meaningful use reporting period into January 2016.

2. CMS should continue to provide flexibility in the meaningful use program reporting periods in future years.

To assist the transition for providers to more advanced Stage 2 objectives, CMS should offer all providers flexibility by shortening the 2016 reporting period to 90 days for all providers, continuing to provide first-time participants with a 90-day reporting period in future years, and establishing a 90-day reporting period for all providers in 2018—the first mandatory year of Stage 3. In the final rule, CMS offers flexibility in 2015 by providing a 90-day reporting period for all providers, but notes that returning providers will have to use a full calendar year reporting period in 2016. We commend CMS for finalizing the shorter reporting period, but also urge the agency to extend this flexibility into 2016. This flexibility will be critical in 2016, as all providers are required to move to modified Stage 2 objectives regardless of which stage they attest to in 2015. Many of the modified Stage 2 objectives, such as electronic prescribing, are not Stage 1 measures for hospitals, so hospitals will benefit from the additional preparation time resulting from a shorter reporting period. The shorter reporting period will allow these hospitals time to adjust to the more stringent requirements of Stage 2 and to prepare for the changed objectives and measures included in the rule, which is particularly important given the delay in the final rule’s release.

A shorter reporting period also is crucial for hospitals in their first year of the program. These hospitals need additional time to make necessary technological and workflow changes as they prepare to report on meaningful use objectives. Therefore, we were encouraged CMS chose to extend the 90-day reporting period for first-time participants to 2017, as the association requested, and we recommend CMS continue offering a 90-day reporting period for first-time participants beyond 2017, as well.

Because CMS finalized its proposal to require all providers to be in Stage 3 in 2018, a 90-day reporting period will be crucial to ensuring successful participation in the program. Additionally, because CMS will require providers to implement a new edition of certified EHR technology (CEHRT) in 2018, a 90-day reporting period will be vital to ensure providers are able to make the necessary upgrades to their systems and take other associated steps, such as training staff and preparing for new measures and objectives.
3. CMS should continue to allow alternate measure exclusions and specifications in 2016 and 2017.

In addition to the flexibility offered by shorter reporting periods, CMS should allow providers who would otherwise have been in Stage 1 to benefit from alternate exclusions and measure specifications in 2016 and 2017. In the rule, CMS offers exclusions on any Stage 2 measures not in Stage 1 for providers who would otherwise be attesting to Stage 1 in 2015. For measures that are in both Stages 1 and 2, but with different requirements or lower thresholds in Stage 1, Stage 1 providers may attest to and meet the Stage 1 version of the measure in 2015.

We are encouraged that, in the final rule, CMS has decided to continue allowing alternate exclusions in 2016 for some measures, such as computerized provider order entry and electronic prescribing for hospitals. However, CMS did not extend the exclusions into 2016 for other measures, most notably the health information exchange and patient electronic access measures. As the 2016 reporting year approaches, it will be vital for the agency to continue allowing these exclusions in coming years. By allowing providers to claim these exclusions, providers who would otherwise be in Stage 1 can build up experience with the Stage 1 equivalent measures before being required to report on more stringent Stage 2 measures. Because the vast majority of hospitals have no experience with measures such as the electronic prescribing measure, either because they are in Stage 1 or because they chose not to report on this menu measure in Stage 2, requiring these measures will be burdensome for hospitals. Being able to claim an alternate exclusion for such measures will give providers sufficient time to prepare their staff and systems for required reporting on Stage 2 measures and specifications.

4. CMS should eliminate the all-or-nothing structure of the program and instead allow hospitals to meet a subset of meaningful use objectives.

To encourage providers to adopt and meaningfully use EHRs, CMS should change the all-or-nothing structure of the program. In its previous form, the meaningful use program required providers to meet and attest to all core objectives and select a subset of menu objectives. In modified Stage 2 and in Stage 3, CMS establishes one set of objectives and associated measures and ends the bifurcation of menu and core objectives. Thus, EHs and EPs are required to meet all eight objectives in Stage 3 and all nine objectives in Stage 2 (10 for EPs). Most of these measures have higher thresholds than in Stage 1 and thus would be more difficult for providers to meet.

Providers already struggle with difficult measures in the program, such as the measure requiring electronic exchange of a summary of care document or the
measure requiring a certain percentage of patients to electronically access their health information. Under the program’s current structure, if a provider meets all objectives and measures except for a single measure under a single objective, the provider is not deemed a meaningful user and will be penalized. Penalizing a provider that is willing and able to meet the thresholds for all of the objectives and measures, but cannot meet the thresholds for one or two measures, is a disincentive to program participation. Moreover, requiring a provider to attest to every measure, including measures that are less relevant to the provider’s particular practice or made more difficult to achieve by the provider’s patient population, can actually become an obstacle to fulfilling the true promise of EHRs. Providers treating a large proportion of low-income or uninsured patients, many of whom are homeless, have a harder time engaging their patients through electronic health information.

To alleviate this concern, giving providers the option to attest to seven out of eight objectives in Stage 3 or eight out of nine objectives in Stage 2, for example, would be a positive step. CMS does provide some limited flexibility within three specific Stage 3 objectives, but this does not go far enough. For the health information exchange and care coordination through patient engagement objectives, CMS requires providers to attest to all three measures under each objective, but they would only have to meet the thresholds for any two of the three measures under each objective. For the public health reporting objectives, EPs will have to report on three of five measures and EHs on four of six measures. This provides flexibility, but because these measures have been historically difficult for providers—and the Stage 3 thresholds are higher than in previous stages—this flexibility is insufficient.

Allowing providers flexibility in choosing meaningful use objectives is also consistent with the direction the program is taking for EPs as they shift to the Merit-Based Incentive Payment System (MIPS). CMS has discussed changing the all-or-nothing approach for EPs in a request for information on the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA). Separate from that rulemaking, CMS should also change the structure for EHs to align the program across provider types. CMS has made many changes in this final rule that are aimed at streamlining the program and reducing confusion, such as by creating a uniform set of objectives and aligning EH reporting periods with EP reporting periods. Giving EHs similar discretion and moving the program away from the all-or-nothing approach would align the program across EHs and EPs. The agency has emphasized its goal of moving providers into alternative payment models (APMs), with the goal of 50 percent of

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Medicare fee-for-service payments being paid through APMs by 2018. Shifting providers to APMs is also one of the goals of the MACRA legislation, with CMS offering bonus payments to physicians who are part of an APM. As both hospitals and physicians are encouraged to move into APMs, such as accountable care organizations, CMS should maintain parity between the structure of physician and hospital measures.

The meaningful use statute provides the agency with broad authority to determine the requirements of information exchange and meaningful use of CEHRT. Therefore, using this discretion, the agency should allow providers to waive one objective and all associated measures under that objective.

5. CMS should revise certain Stage 3 measures to provide additional flexibility for providers

CMS should lower the thresholds for key Stage 3 measures, particularly measures related to health information exchange, patient electronic access, and patient engagement. Until it is clear that providers are prepared to meet more stringent thresholds, CMS should postpone any increases in measure thresholds between Stages 2 and 3. Of particular concern to America’s Essential Hospitals are the following Stage 3 objectives and associated measures:

- Objective 5—Patient electronic access to health information
- Objective 6—Coordination of care through patient engagement
- Objective 7—Health information exchange

These Stage 3 measures have performance thresholds even higher than those finalized for Stage 2, but there is little corresponding evidence that suggests providers will be able to meet the higher thresholds. In 2014, the majority of providers in the program attested to Stage 1 measures and objectives, which do not include more advanced Stage 2 measures requiring patients to view, download, or transmit their data and requiring providers to electronically exchange a summary of care record for transitions of care. By virtue of being in Stage 1, these providers have not been exposed to these measures’ reporting requirements and have not undertaken the necessary system upgrades, workflow adjustments, and staff training to report on them. With regard to those providers that did attest to Stage 2 in 2014, attestation data points to difficulties with measure thresholds. Attestation data from 2015 will not be available until next year, so there also is no

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Recognizing the difficulty providers encounter with these measures, CMS reduced many of the measure thresholds from the original proposed thresholds. However, some of the finalized measure thresholds are still unrealistically high. To allow providers to concentrate their resources on using their EHRs in a way that improves the provision of care and health outcomes, CMS should revise these measures as shown in this table and following comments.

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<tr>
<th>Stage and Objective Description</th>
<th>Description of Final Measure of Concern</th>
<th>Suggested Threshold and Comments</th>
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<tr>
<td>Stage 3 Objective 5: Patient electronic access to health information</td>
<td>Measure 1: For more than 80 percent of all unique patients discharged from the inpatient setting or the emergency department, the EH must provide access for the patient to view, download, or transmit his or her health information online; AND the provider must make the patient’s health information available through an application program interface (API).</td>
<td>Threshold should be reduced to 50 percent and the API should be an alternate means of meeting this objective, not required in addition to the portal.</td>
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<td>Stage 3 Objective 6: Coordination of care through patient engagement</td>
<td>Measure 1: More than 10 percent of the EH’s patients must actively engage with the EHR, by either 1) viewing, downloading, or transmitting their health information; or 2) accessing their health information through the use of an API.</td>
<td>CMS should lower the threshold to 5 percent. We applaud CMS for recognizing the difficulty with this measure and reducing the threshold from 25 percent in the proposed rule, but it should be reduced to 5 percent.</td>
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<td>Measure 2: Send a secure message for more than 25 percent of unique patients.</td>
<td>We recommend that CMS remove this measure for EHs.</td>
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<td></td>
<td>Measure 3: Incorporate patient-generated health data or data from a non-clinical setting for more than 5 percent of unique patients.</td>
<td>We recommend that CMS remove this measure.</td>
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<td>Stage 3 Objective 7: Health information exchange</td>
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<td>Measure 1: Create and electronically exchange a summary of care record for more than 50 percent of transitions or referrals.</td>
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<td>Measure 2: Receive and incorporate an electronic summary of care document into the provider’s EHR for more than 40 percent of transitions or referrals.</td>
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<td>Measure 3: Perform clinical information reconciliation for more than 80 percent of transitions, referrals, or first time patient encounters.</td>
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<td>CMS should reduce the threshold of measure 1 to 10 percent, which is the threshold for modified Stage 2. Furthermore, providers should only be required to meet one of the three measures under this objective.</td>
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Measures dependent on patient action are particularly difficult for essential hospitals, and providers should not be penalized for failing to meet thresholds when performance on a measure is outside of their control. This principle is especially important for providers who disproportionately treat vulnerable populations. Members of America’s Essential Hospitals predominantly serve a diverse mix of patients facing significant socioeconomic challenges and who are uninsured or covered by public programs. Many of these patients are homeless and seek care at homeless health care programs and benefit from respite programs at essential hospitals. In addition to homelessness, patients’ ability to access the technology necessary to meet these measures is affected by a variety of other sociodemographic factors, including income, education, and primary language. Many of these patients do not have electronic access to their health information outside of the hospital. While Internet service may be readily available in most urban areas, many families do not have a computer at home or cannot afford the monthly cost of Internet access. These patient challenges make these measures even more difficult for essential hospitals to meet.

Measure 1 of Objective 5 requires providers to give patients access to their health information through an API that is certified by the Office of the National Coordinator for Health IT (ONC). **We urge CMS to amend the measure to provide APIs as an option, but not require them in addition to requiring providers to give patients access to their health information through a portal.** Providers can use APIs to allow patients to access their health information through third-party applications—such as smartphone applications—instead of being limited to a vendor’s patient portal. The introduction of APIs in Stage 3 is promising because it would give providers and patients a choice of applications through which to access their health information instead of limiting them to a single portal. For hospitals that have not implemented a patient portal because it is financially prohibitive or because the portal does not meet the organization’s
needs, the availability of the API functionality may provide an alternative option to meet this measure.

For these reasons, America’s Essential Hospitals supports the concept of leveraging APIs to satisfy the patient access requirement, in addition to allowing for the current method of meeting this objective. However, much work remains for ONC to develop certification criteria that ensure these APIs meet meaningful use program requirements and have mature standards. There are also privacy and security concerns surrounding the use of APIs and third-party applications. CMS and ONC will need to thoroughly vet these issues before APIs are ready for Stage 3. Until these issues are resolved, America’s Essential Hospitals supports APIs as an additional option to engage patients in their health care but does not believe APIs should be required in addition to the patient portal.

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America’s Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Director of Policy Erin O’Malley at eomalley@essentialhospitals.org or 202-585-0127.