

June 15, 2015

**VIA ELECTRONIC SUBMISSION**

Title: *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017*

Agencies: Department of Health and Human Services Centers for Medicare & Medicaid Services

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**Attention:** Karen DeSalvo, MD, MPH, MSc, National Coordinator for Health Information Technology  
Andrew Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services  
Sylvia Burwell, Secretary, Department of Health and Human Services

Dr. Karen DeSalvo and Acting Administrator Slavitt,

On behalf of the Kentucky Health Information Exchange in the Cabinet for Health and Family Services (CHFS) for the Commonwealth of Kentucky, we would like to respectfully submit to your office for consideration the attached comments, questions, concerns, and recommendations relating to the aforementioned Proposed Rule for the Medicare and Medicaid EHR Incentive Programs Modifications to Meaningful Use in 2015-2017.

The attached is a group effort aggregated from Kentucky providers, hospitals and Meaningful Use subject matter experts who have collaborated on this notice of proposed rulemaking, in the interest of facilitating the strategic initiative towards a fully interoperable and patient-centered electronic health information environment. These partners include the following organizations:

- Kentucky Department of Medicaid Services (EHR Incentive Program)
- Kentucky Health Information Exchange
- Kentucky Regional Extension Center
- Northeast Kentucky Regional Health Information Organization

Please evaluate these collective comments with respect to your office's strategic vision of Meaningful Use and incorporate their influence in the revisions to the EHR Incentive Program. Thank you.

Sincerely,

Polly Mullins-Bentley

State Health I.T. Coordinator, Kentucky Health Information Exchange



## General Comments on Meaningful Use Requirements from 2015-2017

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The move to a calendar year, alignment with objectives and consistent requirements for EHs and EPs are appreciated by providers across the state. We support alignment across programs for ease of provider compliance and we support the overall spirit of this change—to reduce the burden on providers and to have providers and hospitals attest to the same objectives for Stage 3 beginning in 2018. We agree CMS should require 1 full year of EHR reporting in 2017, except for first time meaningful users for the Medicaid EHR program. This is a great way to streamline the program and cause less confusion.

We strongly agree with the provision to allow providers to attest to a 90 day reporting period in 2015. Additionally we agree with allowing hospitals to choose a continuous 90 day reporting period beginning in October 1, 2014- December 30, 2015. Further, we agree with allowing providers in 2016 who are first time meaningful users or who have unsuccessfully demonstrated MU in a prior year to be able to attest to a 90 day period. The move to a consistent reporting period is extremely beneficial to providers and will namely help organizations that attest both as an eligible hospital and also attests their eligible providers.

We agree with the removal of measures that were deemed topped out, duplicative or redundant for both eligible providers and hospitals.

We feel the discussion regarding alternate exclusions is cumbersome to understand and requires further explanation. We request information and greater clarity on whether a provider will still meet meaningful use while claiming exclusions to measures.

We strongly agree with the removal of the 5% threshold for measure 2 and to instead require a greater than 1 patient threshold to meet the view, download, and transport measure. KY strongly agrees with allowing providers to attest yes/no to the secure messaging measure which signifies that the functionality is turned on.

We request clarification on the exclusions for Measure 2 for transitions of care for those providers that were scheduled to meet Stage 1 in 2015.

We agree with bidirectional exchange of immunization data but feel this will be a significant challenge for providers to meet because state immunization registries will not be ready. We feel Measures 3-5 are vague and open to interpretation and we are requesting additional information and greater clarification on these objectives. We would also like greater clarity on the term 'active engagement' given that there are no standards for transport and vendors certify modularly. We would like greater clarity on what the term 'active engagement' means from a technical, administrative, and onboarding perspective. For example, some vendors do not certify their public health interfaces but have interface certification on their road map. Other vendors have a certified interface for public health reporting but they have not developed the transport necessary to send the data to the public health agency.

In regards to measure 2/Syndromic Surveillance reporting, the CDC/BioSense wants all data collected from providers and has specified that no providers are excluded from the objective. If exclusions are

permitted, the Final Rule should clearly specify what diagnoses, diseases, or provider types qualify for the exclusion.

We are requesting greater clarity on the exclusions for measures not counting toward the total measures for public health reporting.

We appreciate the emphasis on public health reporting and the consolidation of the objective. This will reduce confusion and help to streamline the program. However, we would like greater clarification on measures 3, 4 and 5 and the types of data that will be submitted. Additionally, we are seeking clarification on the role that an HIE will play in measures 3-5, and the ways in which providers contribute data and the types of agencies that will be considered. We would like clarification on what counts in regards to the measures above for contributing clinical data to a state-run HIE. We recommend language that allows providers to submit to a state designated HIE for public health registry reporting. We urge CMS to consider the state-run HIE's role with public health reporting when finalizing the proposed rule. KY agrees with allowing providers to submit to multiple registries to count toward the public health objective, however, we request greater clarity on the types of national registries that providers can submit to.

We strongly agree with providing an alternate attestation option for Medicaid providers who are seeking to demonstrate MU to avoid the payment adjustment but are prohibited from switching programs and using the Medicare registration and attestation system to attest to MU without switching programs for the purposes of avoiding the Medicare payment adjustment. However, we would like clarification on how the states will receive the attestation information from the Medicare registration and attestation system. Additionally, KY supports the proposal for changes to the attestation deadline for the purpose of payment adjustments.

KY is supportive of allowing providers the option to electronically submit CQMs as well as manually attest CQM data. On behalf of KY providers, we are requesting clarification on the formal location of finding information regarding CQM certification data. Often websites such as CHPL are not current and/or up-to-date regarding vendor certifications/upgrades for CQMs. We are requesting from CMS a formal location to find this type of information.

KY strongly agrees with adding additional Place of Service codes or settings to the regulatory definition of hospital based EP and feels this addition will enable additional providers to meet meaningful use.

KY agrees with requiring providers to attest to the 90 day period within the first three quarters of CY 2016 and by October 1, 2016 in order for EPs to avoid the payment adjustment in 2017.