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VIA ELECTRONIC SUBMISSION

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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 for Stage 3.

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 Division 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 Stage 3 Meaningful Use Requirements

Topic: 90 Day Reporting Period, Alignment with CY and Requirements, and Stage 3 Onset

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 that CMS should require 1 full year of EHR reporting in 2017. This is a great way to streamline the program and cause less confusion.

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 this change.

Topic: Removal of Topped out Objectives

The removal of measures that were deemed as “topped out,” is helpful as it eases the reporting burden for common place tasks that are commonplace and arise at every encounter. We agree with this change.

Topic: Hardship Exceptions

We agree with these exceptions.

Topic: Clinical Quality Measures

We agree with the e-submission of CQMs.

Topic: EPs practicing in Multiple locations – maintaining Stage 2 final rule

This has historically been cumbersome and should be distinct to the “main” organization the provider works. Often, there is no way a provider can collect these reports from organizations that are not at the same level of meaningful use. Causing a great deal of confusion and making the task a challenge. We anticipate this to continue to be a challenge for providers moving forward.

Topic: ONC certified API

We support giving a choice between an API or a traditional patient portal for providers.

We foresee challenges to measuring patient access and usability of the API. While it may be more convenient for patients to access their PHI on these devices, it may present a potential security risk. We are concerned about the patient interaction with these devices and the training that may be required for patients. Additionally, we would like clarification on how the CMS envisions the technology will be provided and by whom it will be rendered and what type of oversight/security safeguards will be in place?

Comments on Proposed Objectives and Measures for Meaningful Use Stage 3

Program Goal/Objective 1: Protect Patient Health Information	
Proposed Objective	<ol style="list-style-type: none"> 1. Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.
Proposed Measure	<ol style="list-style-type: none"> 1. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process.
Comments	<p>We request that CMS provides greater clarity and detail on if a security risk analysis is required for a version control upgrade.</p>

Program Goal/Objective 2: E-Prescribing	
Proposed Objectives	<ol style="list-style-type: none"> 1. Maintain the objective and measure finalized in the Stage 2 final rule for e-prescribing for EP's, with minor changes 2. EP's must generate and transmit permissible prescriptions electronically, and eligible hospitals and CAH's must generate and transmit permissible discharge prescriptions electronically (eRx).
Proposed Measure	<ol style="list-style-type: none"> 1. Proposed EP Measure: More than 80% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. 2. Proposed hospital CAH Measure: More than 25% of hospital discharge medication orders for permissible prescriptions (for new and changes prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.
Comment	<p>This was expected but this is a high bar to attain. However, providers may be able to meet this threshold by 2018. We have no issues with its inclusion in MU Stage 3, nor the requirements.</p>

Program Goal/Objective 3: Clinical Decision Support	
Proposed Objective	<ol style="list-style-type: none"> 1. Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions. 2. Maintain the Stage 2 objective with slight modifications and further explanation of the relevant point of care, the types of CDS allowed, and the selection of a CDS applicable to a provider’s scope of practice and patient population.
Proposed Measures	<ol style="list-style-type: none"> 1. Proposed to retain both measures of the Stage 2 objective for Stage 3 2. Measure 1: Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs 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. 3. 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
Comment	<p>We have no real issues or changes with this measure and we support retaining this objective and its measures.</p>

Program Goal/Objective 4: Computerized Provider Order Entry (CPOE)	
Proposed Objective	<ol style="list-style-type: none"> 1. Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistance; who can enter orders into the medical record per state, local, and professional guidelines.
Proposed Measures	<ul style="list-style-type: none"> • An EP, eligible hospital or CAH must meet all three measures: <ol style="list-style-type: none"> 1. More than 80% of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE; and 2. More than 60% of laboratory orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE; and 3. More than 60% of diagnostic imaging orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. <p>Experience with Stage 1 and Stage 2 has shown that the denominator for all order created by the EP or in the hospital would not be unduly burdensome for providers and would create a better measurement for CPOE usage, particularly for EP's who infrequently order medications, this does not guarantee such a denominator would be feasible for all providers. CMS invites comments to limit the measure of this objective to those patients whose records are maintained using CEHRT:</p> <p>Proposed Measure 1: To calculate the percentage, CMS and ONC have worked together to define the following for this measure: <i>Denominator:</i> Number of medication orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period <i>Numerator:</i> The number of orders in the denominator recorded using CPOE <i>Threshold:</i> The resulting percentage must be more than 60% in order for an EP, eligible hospital or CAH to meet this measure.</p> <p>Proposed Measure 2: <i>Denominator:</i> Number of diagnostic imaging orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period <i>Numerator:</i> The number of orders in the denominator recorded using CPOE <i>Threshold:</i> The resulting percentage must be more than 60% in order for an EP, eligible hospital or CAH to meet this measure.</p> <p>Proposed Measure 3: <i>Denominator:</i> Number of medication orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period <i>Numerator:</i> The number of orders in the denominator recorded using CPOE <i>Threshold:</i> The resulting percentage must be more than 80% in order for an EP, eligible hospital or CAH to meet this measure.</p>

<p>Comment</p>	<p>We support the change from radiology reports to “diagnostic imaging” language, however, this is a new level of reporting and the threshold has been doubled, which may be challenging for providers to meet. Otherwise we have no issues with the rest of the measures.</p>
<p>Program Goal/Objective 5: Patient Electronic Access to Health Information</p>	
<p>Proposed Objectives</p>	<p>1. Proposed Objective: The EP, eligible hospital or CAH provides access for patients to VDT their health information, or retrieve their health information through an API, within 24 hours of its availability.</p>
<p>Proposed Measures</p>	<p>EP’s, eligible hospitals, and CAH’s must satisfy both measures in order to meet the objective:</p> <p>Proposed Measure 1: For more than 80 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23): (1) The patient (or patient-authorized representative) is provided access to view online, download, and transmit their health information within 24 hours of its availability to the provider; or (2) The patient (or patient-authorized representative) is provided access to an ONC-certified API that can be used by third-party applications or devices to provide patients (or patient-authorized representatives) access to their health information, within 24 hours of its availability to the provider. For measure 1, We propose to increase the threshold for measure 1 from the Stage 1 and Stage2 threshold of 50 percent to a threshold of 80 percent for Stage 3. To calculate the percentage, CMS and ONC have worked together to define the following for this measure: Denominator: The number of unique patients seen by the EP or the number of unique patients discharged from an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period. Numerator: The number of patients in the denominator who are provided access to information within 24 hours of its availability to the EP or eligible hospital/CAH. Threshold: The resulting percentage must be more than 80 percent in order for a provider to meet this measure.</p> <p>Proposed Measure 2: The EP, eligible hospital or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period. For measure 2, we propose to increase the threshold that was finalized in Stage 2 from 10 percent to 35 percent. To calculate the percentage, CMS and ONC have worked together to define the following for this measure: Denominator: The number of unique patients seen by the EP or the number of unique patients discharged from an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period. Numerator: The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT. Threshold: The resulting percentage must be more than 35 percent in order for a provider to meet this measure.</p>

Comment

Regarding certified APIs, this may be a challenge for the ONC to complete. Additionally, we foresee privacy issues that may arise. We support making an ONC-certified API an option for meeting measure 1 but not a requirement as it is still too new.

Measure 2 of this requirement has language that may present unique challenges. Providing patient education electronically, for many providers, requires that it be made available via a patient portal. Currently, this is a major change from Stage 2 and may present difficulties for providers in Kentucky as some have chosen to implement a patient education module that was not integrated into their EMR and made use of the “Infobutton” capabilities. Providers have commented that the use of Infobutton should be a requirement of 2015 CEHRT edition for patient education and should be made available electronically. Otherwise, providers will be forced to implement new education modules, which would be a financial burden to several. We are concerned about the provider difficulty in measuring electronic access to clinically relevant patient education materials. We know based off of surveying our providers that the 35% threshold is a high threshold for providers to meet in our state.

Program Goal/Objective 6: Coordinated Care Through Patient Engagement

<p>Proposed Objective</p>	<p>1. Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient’s care.</p>
<p>Proposed Measures</p>	<p>Proposed Measures: We are proposing that providers must attest to the numerator and denominator for all three measures, but would only be required to successfully meet the threshold for two of the three proposed measures to meet the Coordination of Care through Patient Engagement Objective. These three measures support the communication continuum between providers, patients, and the patient’s authorized representatives through the use of view, download, and transmit functionality.</p> <p>Proposed Measure 1: During the EHR reporting period, more than 25 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) actively engage with the electronic health record made accessible by the provider. An EP, eligible hospital or CAH may meet the measure by either More than 25 percent of all unique patients (or patient-authorized representatives) seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period view, download or transmit to a third party their health information; or (2) More than 25 percent of all unique patients (or patient-authorized representatives) seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period access their health information through the use of an ONC-certified API that can be used by third-party applications or devices.</p> <p>Proposed Measure 2: For more than 35 percent of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient’s authorized representatives), or in response to a secure message sent by the patient (or the patient’s authorized representative). For measure 2, we propose to increase the threshold for this measure over the threshold for the Stage 2 measure because for Stage 3 provider initiated messages would count toward the measure numerator. we propose to include in the measure numerator situations where providers communicate with other care team members using the secure messaging function of certified EHR technology, and the patient is engaged in the message and has the ability to be an active participant in the conversation between care providers</p> <p>Proposed Measure 3: Patient generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15 percent of all unique patients seen by the EP or discharged by the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period. For measure 3, EPs, eligible hospitals, and CAHs (or their authorized representatives) must incorporate health data obtained from a non-clinical setting in a patient’s electronic health record for more than 15 percent of unique patients seen during the EHR reporting period.</p>

Comment

The proposal to attest to all 3 measures, but only meet 2 of the 3 to achieve MU is reasonable however; we feel these measures will be difficult for providers to attain.

Measure 1 may be difficult to achieve for many providers in Kentucky. It has taken a great effort for providers to attain the greater than 5% requirement of patient portal use. We are concerned about broadband availability as we do not feel that access to 4Mb Broadband connotes that patients have access to a computer or internet services. We support making ONC certified API an option for meeting measure 1 as the technology is too new.

Measure 3 may present challenges to achieving. It may be challenging for patients to bring their data to healthcare providers for the purposes of importing that information into their EHR systems. There may also be issues that arise with validating the data that is populating the EHR. We anticipate changes to HIPAA regulations that may determine if this patient generated data is now a part of the legal health record. We foresee challenges with getting a unified data set for this measure as the data will be coming from multiple data sources. We recommend a required list that can be made standard so that vendors can build data sets to accept this information. Additionally, we feel that the data should be reviewed and vetted before being inputted into the system.

We feel that these measures will be difficult to attain as they are contingent on elements outside of the provider's control. If the 2015-2017 modifications are finalized, we foresee challenges that may arise with regards to patient electronic access as it may be difficult to attain these thresholds. We feel that rural providers especially may encounter significant challenges and barriers to meeting these high thresholds.

Additional comments:

Currently several providers are meeting the online access threshold by retaining logs of patients that do not have email addresses and are handing them written instructions. We are requesting clarification on if this would be acceptable for meeting the measure in Stage 3.

We are requesting greater clarity on the definition of a *contributor* in discussing a patient's care.

We agree that the provider has the ultimate decision on what they deem relevant and that the provider can exclude certain conversations from patient view.

We agree with the definition of a *non-clinical setting*.

We agree that the measures should be split into two categories of clinical vs non-clinical settings.

The denominator should be all unique patients and not just those with multiple visits.

Program/Goal Objective 7: Health Information Exchange	
Proposed Objective	The EP, eligible hospital, or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of certified EHR technology.
Proposed Measures	<p>Proposed Measures: We are proposing that providers must attest to the numerator and denominator for all three measures, but would only be required to successfully meet the threshold for two of the three proposed measures to meet the Health Information Exchange Objective.</p> <p>Proposed Measure 1: For more than 50 percent of transitions of care and referrals, the EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.</p> <p>Measure 1: To calculate the percentage of the first measure, CMS and ONC have worked together to define the following for this measure: 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 exchanged electronically. Threshold: The percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.</p> <p>Proposed Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital or CAH incorporates into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system.</p> <p>Measure 2: To calculate the percentage of the second measure, CMS and ONC have worked together to define the following for this measure: Denominator: Number of patient encounters during the EHR reporting period for which an EP, eligible hospital, or CAH was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available. Numerator: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology. Threshold: The percentage must be more than 40 percent in order for an EP, eligible hospital,</p> <p>Proposed Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital, or CAH performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets:</p> <ul style="list-style-type: none"> • Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. • Medication allergy. Review of the patient's known allergic medications. • Current Problem list. Review of the patient's current and active diagnoses. For the first measure, we are maintaining the requirements established in the Stage 2 final rule to capture structured data within the certified EHR and to generate a summary of care document using CEHRT for purposes of this measure (77 FR 54014). For purposes of this measure, we are requiring that the summary of care document created by CEHRT be sent electronically to the receiving provider. <p>Measure 3: To calculate the percentage, CMS and ONC have worked together to define the following for this measure: Denominator: Number of transitions of care or 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 recipient of the transition or referral or has never before encountered the patient. Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list. Threshold: The resulting percentage must be more than 80 percent in order for an EP, eligible hospital, or CAH to meet this measure.</p>

Comments

Providers have reported that they indeed do have the capabilities for meeting measure 1, but are however limited by where providers send their patients and whether those providers can accept a summary of care record electronically. Several providers across the state have had difficulty and struggle to meet the current 10% threshold for Stage 2 today. Several providers transition their patients to long-term care/post-acute care facilities after they are discharged, and this population has been excluded from the EHR Incentive Program. Further, several do not attain the technology to receive summary of care records electronically as they do not have in place a certified EHR system with capabilities to receive CCDAs. Additionally the choice of Direct protocol standards has created problems where interoperability between two Direct-enabled EHRs is not guaranteed. Without an incentive to accept summary of care records electronically, several struggle to equip themselves with the necessary technology to meet the requirements. Equipping these facilities with a web-based application to receive CCDAs presents issues as well. Some of the challenges include: the workflow changes, potential fees/costs, the time required for training the providers, and the change management processes that may need to occur.

Additionally, we would like clarification on what constitutes an exchange and what *exchange* documentation is needed for proof for measure 1. What proof do providers need to validate that the messages have been successfully received as a form of documentation? Today, several vendors have not developed the technology to receive CCDAs via direct secure messaging into their CEHRT. This has been a major issue with care transitions. Without providers having the capability to receive inbound, providers cannot attain interoperability.

Measure 2 provides more challenges. Several patients referred to hospitals are transitioned from nursing homes and thus will not have a summary of care record available to be queried as those nursing facilities often do not have a certified EHR system.

We believe that information reconciliation could be accomplished manually or through automated functionality. The introduction of a threshold of 80% for a new measure may be too high and difficult to achieve for providers.

We appreciate the definition of *referral* and this definition was greatly needed in Stage 2 and will thus allow providers to count a greater number of transitions in their numerator. We also appreciate the definition of what counts for the TOC denominator. Also, allowing providers to count those that are sharing the same CEHRT database is helpful for provider. The distinct billing identity is a clear way to distinguish what counts and what does not.

We would like to see added language about query-based exchange and the ways in which CMS intends on accommodating it. Additionally, we strongly recommend that the sending provider be permitted to send the summary of care records through an HIE infrastructure and will count towards the measure. Furthermore, aggregation of data in a query based HIE infrastructure greatly improves transitions of care and allows the data to be easily retrieved via query at any time in the future by other providers who may treat that patient.

Program Goal/Objective 8: Public Health and Clinical Data Registry Reporting	
Proposed Objective	The EP, eligible hospital, or CAH is in active engagement with a PHA or CDR to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.
Proposed Measures	<p>Proposed Measures: We are proposing a total of six possible measures for this objective. EPs would be required to choose from measures 1 through 5, and would be required to successfully attest to any combination of three measures.</p> <p>Proposed 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).</p> <p>Proposed 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).</p> <p>Proposed 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.</p> <p>Proposed 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.</p> <p>Proposed Measure 5: Clinical Data Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry.</p> <p>Proposed Measure 6: Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results. This measure is available to eligible hospitals and CAHs only. Electronic reportable laboratory result reporting to PHAs is required for eligible hospitals and CAHs in Stage 2 (77 FR 54021). We propose to retain this measure for Stage 3 to promote the exchange of laboratory results between eligible hospitals/CAHs and PHAs for improved timeliness, reduction of manual data entry errors, and more complete information.</p>
Comment	<p>We are concerned that the requirement for receiving data back in measure 1 (immunization reporting) will be a challenge to meet and we are proposing that it be optional for providers. 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 the term ‘active engagement’ and what that means from a technical and administrative processes and onboarding. 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.</p> <p>In regards to measure 2, 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.</p> <p>We are requesting greater clarity on the exclusions for measures not counting toward the total measures.</p> <p>We appreciate the emphasis on public health reporting and the consolidation of the objective. This will reduce confusion and help to streamline the program.</p>

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.