### The Medicare and Medicaid Electronic Health Record Incentive Program

#### Stage 3 Summary of Final Rule

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<tr>
<th>Stage 3 Proposed Measure</th>
<th>CHA Original Comments and CMS's Response</th>
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<tr>
<td><strong>Objective 1: Protect Patient Health Information</strong> – Protect ePHI created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.</td>
<td>Finalized as proposed.</td>
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<tr>
<td><strong>Measure finalized as:</strong> Conduct or review a security risk analysis, including addressing the security (including encryption) of data created or maintained stored in Certified EHR Technology (CEHRT), implement security updates as necessary, and correct identified security deficiencies as part of the provider’s risk management process.</td>
<td>We request that CMS provide clarification on how this proposed policy relates to FAQ 10754, which indicates completion of the risk analysis once a year continues. With Medicaid first year providers reporting a 90-day period, for organizations that have multiple EPs with multiple reporting periods in a year, requiring a risk assessment by that organization for each of the EPs’ reporting periods creates administrative inefficiencies for the organization. Repeating the risk analysis within a short period of time does not change the nature of the risk being analyzed or the effectiveness of addressing the risk. We request that the final rule continue to support previous clarification that not all security deficiencies need to be corrected within the reporting period. CMS clarified that a security risk analysis is not a discrete item in time, but a comprehensive analysis covering the full period of time for which it is applicable; and the annual review of such an analysis is similarly comprehensive. The analysis and review are not merely episodic but should cover a span of the entire year, including a review planning for future system changes within the year or a review of prior system changes within the year. The measure must be completed in the same calendar year as the EHR reporting period. If the EHR reporting period is 90 days, it must be completed in the same calendar year. This may occur either before or during the EHR reporting period; or, if it occurs after the EHR reporting period, it must occur before the provider attests or before the end of the calendar year – whichever date comes first.</td>
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<td><strong>Objective 2 finalized as: Electronic Prescribing</strong> – EPs, EHs, and CAHs must generate and transmit permissible prescriptions electronically, (eRx), and EHs and CAHs must generate and transmit permissible discharge prescriptions electronically.</td>
<td>Generally, clinicians support e-prescribing if it is efficient. However, there are situations when e-</td>
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<td><strong>EP Measure finalized as:</strong> More than 80%</td>
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percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

This is up from 50 percent in Stage 2.

**EH/CAH Measure finalized as:** More than 25 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.

This is up from 10 percent in Stage 2.

**Prescribing is problematic:**
- There is no standard for pediatricians transmitting compounded medications.
- There is also poor adaptability to transmitting doses that are different at varied times of day (a frequent occurrence for seizure medications for children).
- There are also instances when insurance companies require paper-based information, which leads to double the work.

CHA believes the 80 percent threshold for all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT is too high. With current workflow challenges and some of the aforementioned issues, some providers are hesitant to do two-way prescribing and default to printing if they are prescribing controlled substances and other medications. This makes it hard to achieve this measure. This threshold is also particularly difficult to meet for providers who primarily serve populations outside of national HIE networks, such as international patients. In addition, some children's hospitals have issues with inclusion of state specific controlled substances being included in reporting (e.g. growth hormone is a controlled substance in at least one state).

Therefore CHA recommends the following thresholds for EPs and EH/CAH. In addition, there should be a way to exclude patients that fall outside of the HIE networks from the denominator.

**Proposed EP Measure**
We recommend 70 percent as a reasonable threshold. This will lessen provider burden as it requires a less dramatic increase from the thresholds for Stages 1 and 2. CMS finalized a threshold of 60 percent.

CMS is maintaining the query function. However, providers are only required to meet this part of the measure to the extent that such a query is automated by their CEHRT and to the extent that a query is available and can be automatically queried by the provider. This means that if a query using the function of their CEHRT is not possible or shows no result, a provider is not required to conduct any further manual or paper-based action in order to complete the query, and the provider may count the prescription in the numerator.

**Proposed EH/CAH Measure**
We recommend keeping the 25 percent threshold for hospitals.

CHA agrees with CMS's proposal to continue to exclude over-the-counter medicines from the definition of a prescription.
We support the exclusion for EPs who write fewer than 100 permissible prescriptions.

CHA would also like to raise a concern related to transmission of patient weight, which is not part of the standard transaction for eRx. This is impacting the workflow of eRx as pharmacy follow-up is required since most pediatric dosing is based on weight.

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<th>Objective 3: Clinical Decision Support (CDS)</th>
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<td>Implement CDS interventions focused on improving performance on high-priority health conditions. <strong>Finalized as proposed.</strong></td>
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**Measures:** EPs, EHs, and CAHs must satisfy both measures in order to meet the objective:

**Measure 1:** Implement five CDS 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, EH, or CAH's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions. **Finalized as proposed.**

**Measure 2:** The EP, EH, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. **Finalized as proposed.**

Since there are few CQMs that pertain to pediatrics, the value of aligning CDS with these measures is not significant. Therefore, we recommend that the “related to four or more CQMs” be removed. We also believe this will allow a hospital more flexibility to align the CDS with its internal quality goals.

However, we do recognize that CMS notes in the proposed rule that absent four CQMs to the provider’s scope of practice or patient population, the CDS intervention must be related to high-priority health conditions. CHA is supportive of this.

If CMS plans to specify which drug-drug interaction checks, we urge CMS to consider a minimum approved set for pediatric drug-drug interaction-checking. We recommend referencing The “Core Drug-Drug Interaction Alerts for Inclusion in Pediatric Electronic Health Records with Computerized Prescriber Order Entry (CPOE)” that appeared in the *Journal of Patient Safety* in March 2014. This article outlines a core list of 19 high value pairs for electronic drug-drug interaction alerts to be recommended as high value alerts in prescriber order entry software used with a pediatric patient population. For example, such drug-drug interactions between amniodarone and digoxin, methadone or warfarin; amitriptyline and sertraline or trazodone; ciprofloxacin and theophylline; among others.

CMS state that providers who are not able to identify CQMs that apply to their scope of practice or patient population may implement CDS interventions that they believe are related to high-priority health conditions relevant to their patient population and will be effective in improving the quality, safety or efficiency of patient care. These high priority conditions must be determined prior to the start of the EHR reporting period in order to implement the appropriate CDS and allow for improved performance.
**Objective 4: CPOE** – Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed health care professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines. **Finalized as proposed.**

**Measures:** EPs, EHs, and CAHs must meet all three measures.

**Measure 1 finalized as:** More than 60% percent of medication orders created by the EP or authorized providers of the EH’s or CAH’s inpatient or ED during the EHR reporting period are recorded using CPOE.

**Measure 2:** More than 60 percent of laboratory orders created by the EP or authorized providers of the EH’s or CAH’s inpatient or ED during the EHR reporting period are recorded using CPOE. **Finalized as proposed.**

**Measure 3:** More than 60 percent of diagnostic imaging orders created by the EP or authorized providers of the EH’s or CAH’s inpatient or ED during the EHR reporting period are recorded using CPOE. **Finalized as proposed.**

**Objective 5: Electronic Access to Protected Health Information (PHI):**

*Objective Finalized as:* The EP, EH, or CAH provides access for patients (or patient-authorized representative) with timely electronic access to view online, download, and transmit their health information, or retrieve their health information and patient specific education through application program interfaces (API), within 24 hours of its availability.

CHA appreciates that CMS no longer requires patient action in order for EPs, EHs, and CAHs to meet the threshold. However, we do want to express that there is continued concern by hospitals and providers that by holding EHs and EPs responsible for patient engagement, EHs and EPs will struggle to meet all measures under patient electronic access, coordination of care, and health information exchange. Organizations can only create the availability and awareness that PHI is available. They cannot require patients to access it. CMS notes that at a basic level, the EHR Incentive Program requires that providers give their patients access to their health information to be able to perform three activities: view their information, download their information, and transmit their information. CMS believes this is a nuanced but important distinction between the existing Stage 2 requirement and the current systems that are used to meet it. The distinction is important: not only does CMS not require a “patient portal” format for VDT, they also do not advocate such a limit on innovation in software or systems designed to allow patients to access and engage with their health information. CMS
believes the efficacy of the health IT environment now and the potential for future innovation relies on the establishment of clear standards and functionality requirements paired with the flexibility to develop differentiated technical specifications, functions, and user interface design.

We also ask that CMS address the challenge for pediatric institutions to meet all measures under patient electronic access, coordination of care, and health information exchange due to the complexities surrounding pediatric patient populations, such as patient proxies and pediatric/adolescent privacy laws. CMS notes that this proposed objective is entirely focused on the provision of access to patients or their authorized representatives and does not require the provider to be accountable for the patient using that access. Additionally, the numerator is calculated based on the provision of access by the provider, not based on whether a patient possesses or can obtain technology for their own use. The provision of access by the provider is the entirety of the measurement and any subsequent barriers to access which are outside the provider’s control do not affect the numerator calculation. In other words, for this measure the provider must ensure the patient has been provided the information they would need to gain access – whether or not the patient has the technology they need to gain access.

### Measures

**Measures:** EPs, EHs, and CAHs must satisfy both measures in order to meet the objective.

**Measure 1 finalized as:** For more than 80 percent of all unique patients seen by EP or discharged from the EH or CAH inpatient or ED:

- The patient (or authorized representative) is provided **timely** access to view online, download, and transmit their health information within **24 hours of its availability to the provider**, and
- The provider ensures the patient’s health information is available for the patient (or authorized representative) to **is provided access using any application of their choice that is configured to meet the technical specifications of the API in the provider’s CEHRT to an ONC-certified API that can be used by third-party applications or devices to provide patients (or authorized representatives) access to their health information within **24 hours of its availability to the provider**.

**Measure 2:** The EP, EH, or CAH must use

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<th><strong>Proposed Measure 1</strong></th>
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<td>CHA supports the flexibility of offering both the portal and API as options. However, children’s hospitals have a number of concerns with raising the threshold to 80 percent:</td>
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<td>- Children who are under 13 years of age are not allowed direct access to their PHI. As a result their guardian must be present to be given proxy access to their child’s PHI. Non-guardians – such as children with foster parents, temporary court ordered care providers (i.e., extended family, friends, etc...), even a parent designated care provider – do not qualify as the guardian to be given such access.</td>
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<td>- Similarly, pediatric providers that work with high Medicaid populations may run into a disproportionately higher number of difficult-to-address guardianship disputes, non-traditional family structures, primary caregivers that have not received formal legal authorizations, undocumented children, or other related situations.</td>
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<td>- Organizations serving lower socioeconomic groups may also have difficulties meeting this threshold if patients and their families are not able to access the information electronically.</td>
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<td>- Some children’s hospitals have non-English speaking limitations in the portal product that could impact meeting this threshold. The portal would have to offer multiple languages to make the 80 percent threshold more realistic.</td>
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Given these concerns, CHA recommends keeping the threshold at the current level or increasing it to no more than 60 percent. In addition, CHA believes an exclusion should be available to providers giving care to patients at risk (e.g., patients subjected to sexual abuse, neglect, drug abuse, court involvement, etc…). For children at risk, providing PHI access to the person with parental rights could cause further harm to the child and therefore would be inappropriate.

We recommend that everyone associated with the patient should receive “credit” for all aspects of electronic communication. A patient viewing the information should be considered as the
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 EH or CAH inpatient or ED during the reporting period.

Finalized as proposed.

Questions related to billing, scheduling of appointments, or administrative subjects should also count towards meeting this measure. Since the goal is to actively engage the patient in their health care via access to information, administrative functions are a part of healthcare delivery. Having patients and their families engage in these functions demonstrates that the clinical community is working to engage the patient electronically.

In addition, while the 24 hour deadline might be doable in some situations, we urge CMS to consider the specific needs and sensitivities in transmitting information for pediatric populations. For instance, certain types of information may require proper communication from a provider to a parent, guardian, or authorized representative before being made available online. Thus, this deadline might not be realistic in all circumstances. CMS recognizes that a review may be required in certain cases where the disclosure or non-disclosure cannot simply be automated. CMS also recognizes that providers’ workflows, especially EPs in small practices, may be impacted in these instances where such a need arises. Therefore CMS is finalizing that information must be included for access within 48 hours for EPs and are retaining the current 36 hours for EHs and CAHs.

CHA also requests clarification on a couple of items:
- “Providing access” when patient or family have opted-out. In pediatrics, access to the patient portal needs intervention to clarify legal guardianship before an invitation can be extended for portal access.
- That the numerator and denominator include documentation of opt-out as well as opt-in. Please clarify that a provider would not be penalized for an opt-out decision by a patient’s family.
- The proposed rule states: “[a]dditionally, this objective should not require the provider to make extraordinary efforts to assist patients in use or access of the information, but the provider must inform patients of these options, and provide sufficient guidance so that all patients could leverage this access.” We request greater clarity on the definition of “extraordinary efforts.” Hospitals can only create the availability and awareness.

Proposed Measure 2
CHA believes the recommended threshold of 35 percent is too high and too much of an increase from the current 5 percent. Patient-specific education printed and given to the patient is a functional method for providing education, especially for organizations treating patients in an urban or inner-city setting. Eliminating paper-based patient education will have a negative effect on such patient populations. The threshold also fails to consider the availability and use of pre-made, patient-specific educational tools that may be paper-based.
CMS should consider EHs that have a high percentage of critical care patients that have complex or specific educational requirements which would not be included in a standard content offering and which could be shared electronically via the portal.

CMS must also take into consideration the fact that electronic sources of patient information do not exist for highly specialized pediatric conditions. For example, children’s hospitals are able to easily access electronic handouts for otitis media or scoliosis, but it is much harder to get electronic sources for conditions such as graft-versus-host disease or recessive dystrophic epidermolysis bullosa.

We recommend keeping the threshold the same as Stage 2 (5 percent) or raising it to no more than 20 percent.

CMS is finalizing Measure 2 as proposed for the method of delivery and with a modification to specify that for the numerator of Measure 2 for each year, the action must occur within the same calendar year as the EHR reporting period, but may occur before, during, or after the EHR reporting period if the EHR reporting period for the provider is less than a full calendar year.

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<th>Objective 6: Coordination of Care through Patient Engagement finalized as:</th>
<th>Use communication functions of certified EHR technology to engage with patients or their authorized representative about the patient’s care.</th>
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<td><strong>Measures:</strong> CMS proposes 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 in this objective.</td>
<td><strong>Proposed Measure 1</strong> EPs and EHs can only create the availability and awareness. Therefore, CHA believes that the 25 percent threshold is too high.</td>
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<td><strong>Measure 1 finalized as:</strong> During the EHR reporting period, more than 1025 percent of all unique patients (or their authorized representatives) seen by the EP or discharged from the EH or CAH inpatient or ED actively engage with the EHR made accessible by the provider. This measure may be met by either:</td>
<td>The threshold included in the proposed 2015-2017 modifications rule is 1 patient because of the problems implementing this measure for Stage 2. Given the issues implementing this measure for Stage 2, requiring a leap from 5 percent to 25 percent seems unattainable for an overwhelming number of providers.</td>
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<td>- More than 25 percent of all unique patients (or authorized representatives) seen during the EHR reporting period view, download, or transmit to a third party their health information; or</td>
<td>This measure can also be a challenge for hospitals that see certain patients infrequently but share the information with primary care providers (PCPs). Many times these patients will go to the PCP’s portal to retrieve information instead of the hospital portal. In the interest of care coordination, we see this as a positive development, and it should not be held against hospitals.</td>
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<td>We recommend that this threshold stay at 5 percent or increase to no more than 10 percent. This can be achieved by dropping the numerator and changing the denominator of the measure. Rather than unique patients, the denominator should be limited to patient populations who are most likely to access the portal, such as those who have had two or more visits at the EH in the past year. In</td>
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More than 25 percent of all unique patients (or authorized representatives) seen 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 chosen by the patient and configured to the API in the provider’s CEHRT; or devices.

A combination of (1) and (2)

**Threshold for 2017:** The resulting percentage must be more than 5 percent.

**Threshold for 2018 and subsequent Years:** The resulting percentage must be more than 10 percent.

**Measure 2 finalized as:** For more than 25 percent of all unique patients seen during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or authorized representative), or in response to a secure message sent by the patient (or authorized representative). For an EHR reporting period in 2017, the threshold for this measure is 5 percent rather than 25 percent.

**Measure 3 finalized as:** Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP or discharged by the EH or CAH inpatient or ED during the EHR reporting period.

For this measure only, CMS proposes that “non-clinical setting” is defined as a setting with any addition, we urge CMS to allow for any VDT that occurs during a hospital stay to count towards the numerator. For EHs, much of the portal or access benefit would occur during the visit, especially for patient families of pediatric or neonatal patients.

CMS believes that 10 percent is a reasonable threshold for providers participating in 2018 as compared to the proposed 25 percent threshold, and should be attainable by providers. CMS will monitor performance on the measure to determine if any further adjustment is needed prior to 2018 and to potentially set another incremental increase toward the proposed 25 percent threshold in a subsequent year.

**Proposed Measure 2**
CHA has concerns with increasing the secure messaging measure threshold to 35 percent. Inpatient care is done by hospitalists, neonatologists, and intensivists. Continuity is not the focus of those types of providers and therefore accountability shifts to the primary/referring provider, who is often in another setting. Therefore, we feel that this is too aggressive for EHs since the intent for most inpatient visits is to treat and transfer back to the primary care team. Many patients will follow up with their PCP and not the doctor they saw during the hospital stay. Furthermore, CHA urges CMS to qualify “secure messaging” and the types of activities it does or does not encompass.

CMS asked for comments on whether any provider who contributes to a message during the reporting period be allowed to count the communication. CHA supports counting any provider who contributes to a message to the patient during the reporting period.

We ask that CMS clarify the definition of “Care Team Members.” Would this include social workers, dietitians, school nurses, physical therapists, community case managers, etc.? If so, this would require secure methods for messaging these providers, which is not standard. If these types of providers are not included, we would urge CMS to consider a lower threshold.

CMS believes that a 25 percent threshold would be an attainable goal for providers in 2018 because the measure focuses on provider-initiated action and offers multiple paths for success; while the reduction from 35 percent reduces the risk of failure for those providers who may require additional time to implement the functions and workflows within their practice.

**Proposed Measure 3**
This measure should only require that the provider has the capability to receive generated data as discrete, structured data, whether via interface upload or via entry into the patient portal. In addition, this measure is applicable to providers that have an ongoing provider-patient relationship.
provider who is not an EP, EH, or CAH as specified for the Medicare and Medicaid EHR Incentive Programs and where the care provider does not have shared access to the EP, EH, or CAH’s certified EHR.

There are many instances where a patient may have only one encounter with a provider/hospital admission for which there is no indication for patient-generated health data or data from a non-clinical setting. There are many scenarios where certain specialties or treatment models simply do not rely on the type of clinical interaction that would benefit from patient-generated data. Since this functionality is not required for Stage 2, establishing such a high threshold for Stage 3 is an unproven and impractical expectation. As a result, establishing a threshold is unrealistic in many circumstances.

CMS agrees to reduce the required threshold for this new measure and function to promote adoption with an attainable goal. They reduced the threshold to 5 percent for the measure.

Therefore, we recommend measuring that the functionality is fully enabled for patients to input their data if it is appropriate for their personal management of their health status. The other option would be to exclude this requirement for specialists who do not feel this fits within their scope of practice.

We also request that CMS clarify “patient-generated health data or data from a non-clinical setting is incorporated into the CHERT…” If the expectation is that clinical data—such as blood pressure, weight, or blood sugar readings—be entered into the record by patients, it is unreasonable to expect that 15 percent of the patient population of a general pediatric EP would have relevant data to enter. There are not many opportunities for pediatric patients to enter clinical data into the record. Unlike adults, most pediatric patients are healthy and free of chronic disease. Not all clinicians incorporate patient-generated data into their EMR so this could be an issue if providers do not have the workflow in place. Moreover, patient-generated or non-clinical generated information for EH does not make sense. The patient is in the hospital and the hospital is collecting information with our systems in place.

In the proposed rule, CMS asked several specific questions regarding this measure. Below are the questions and CHA’s responses.

- Should the data require verification by an authorized provider?
  No, if it is reported by the patient/other, how can a provider verify it?

- Should the incorporation of the data be automated?
  It should be accessible within the EHR, but not required to be incorporated into the EHR.

- Should there be structured data elements available for this data as fields in an EHR?
This should not be a requirement. Patients/families may document on a log, and that should count.

- Should the data be incorporated in the CEHRT with or without provider verification? It should be accessible via the CEHRT, but not incorporated unless verified.
- Should the provenance of data be recorded in all cases and for all types of data? Yes.

Finally, we do not feel this measure should be split into two separate measures. On its own, it will be very difficult for certain specialties to meet, and separating it into two separate measures with two separate thresholds would add additional complexity and difficulty.

**Objective 7: Health Information Exchange**

**Objective finalized as**: The EP, EH, or CAH provides a summary of care record when transitioning or referring their patients to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or 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. CMS is also proposing that the receipt of the summary of care document (CCDA) may be passive (provider is sent the CCDA and incorporates it) or active (provider requests a direct transfer of the CCDA or provider queries an HIE for the CCDA).

**Measures**: CMS proposes 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.

**Measure 1**: For more than 50 percent of transitions of care and referrals, the EP, EH, 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. **Finalized as proposed.**

**Proposed Measure 1**
CHA believes that the 50 percent threshold is too high.

To achieve the 50 percent threshold, the summary of care would require significant enhancements of current Health Information Service Provider (HISP). This would need to include common data elements that are required and improve interoperability between existing HISPs.

The sending of electronic summary of care documents for transitions of care and referrals measure relies on external providers. External providers, such as smaller physician practices, may not have the capability to implement the functionality necessary to receive electronic summary of care documents. Moreover, EHs and EPs should not be held accountable for the inactions or inabilities of external providers to receive electronic summary of care documents. Some children’s hospitals reported that they often bear the financial burden of establishing mailboxes for external providers to receive the transmitted information. Thus, the threshold should account for the fact that the infrastructures (or
EHR an electronic summary of care document from a source other than the provider’s EHR system.

**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, EH, or CAH performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets:
- Medication
- Medication allergy
- Current problem list

Finalized as proposed.

lack of infrastructure) used by external providers are outside of the referring provider or hospital’s control.

For these reasons, CHA recommends that the threshold for this measure remains at 20 percent. CMS disagrees and believes the threshold is reasonable.

**Proposed Measure 2**
This measure is dependent on the referring provider having the capability to send a summary of care electronically. As an organization, hospitals receive a number of referrals, yet they have no control over the technologic capabilities of the providers who are referring the patients.

Furthermore, this measure is dependent on having an interoperability infrastructure in place to facilitate the electronic exchange of information. This infrastructure is only partially available and the timeline for its completion is currently unknown. Consequently, some children’s hospitals have reported difficulty meeting even a 10 percent threshold. Since this proposed measure is totally dependent upon the referring provider’s ability to send the CCDA to an organization or for each individual EP and this was not a Stage 2 requirement, we believe establishing a threshold is unrealistic at this time. We propose that a more realistic measure would capture whether the EP, EH, or CAH has enabled the functionality to incorporate the electronic summary of care document from a source other than their own EHR system. Since this will be the first time some hospitals have to meet the threshold, it will take time to ensure the referring providers are prepared to send CCDAs. CMS does not think the threshold is too high.

In addition, patients are given the flexibility to transition their care to whomever they select, which may or may not be known at the time of the referral. With this unknown, having the document electronically submitted as a requirement would create a hardship on both the patient and the provider to close the required loop.

CMS sought comment on whether “electronic alerts received by EPs from hospitals when a patient is admitted, seen in the emergency room or discharged from the hospital—so called ‘utilization alerts’—should be included in measure two, or as a separate measure.” We recommend that CMS not include electronic alerts because the receiving provider would be accountable for processing such alerts and health information exchanges are not mature enough for this yet.

**Proposed Measure 3**
CHA believes the 80 percent threshold is too high. Given that there are many pediatric practices that are paper-based whose clientele is commercial insurance and do not take Medicaid, these
providers have no reason to convert to an electronic medical record. This places the burden on the hospital/provider, who can only control what they send – not what they receive. We believe a 50 percent threshold – as required for Stage 2 – is more reasonable and should be retained. At the same time, we support the overall movement of the industry towards supporting clinical information reconciliation, and propose that EPs, EHs, and CAHs put the necessary workflows in place to move towards this general goal. CMS does not think the threshold is too high.

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<th>Objective 8: Public Health and Clinical Data Registry Reporting</th>
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<td><strong>Proposed Objective:</strong> The EP, EH, or CAH is in active engagement with public health agencies (PHA) or clinical data registries (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. <strong>Finalized as proposed.</strong></td>
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For Stage 3, CMS proposes to remove the prior “ongoing submission” requirement and replace it with an “active engagement” requirement. 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. CMS proposes that “active engagement” may be demonstrated by any of the following options:

- **Active Engagement Option 1 – Completed Registration to Submit Data** – The EP, EH, 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, EH, or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation.

- **Active Engagement 2 – Testing and Validation** – The EP, EH, 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, EH, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR. CMS also proposes to create a centralized repository of national, state, and local PHA and CDR readiness.

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<th>Measures: CMS proposed six possible measures. EPs would be required to choose from measures one through five, and would be required to successfully attest to any combination of three measures. EHs and CAHs would be required to choose from measures one through six, and would be required to successfully attest to any combination of four measures.</th>
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<th>Measure 1 – Immunization Registry Reporting: The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data and receive The proposal to provide support to providers seeking to meet the requirements by creating a centralized repository of national, state, and local PHA and CDR will be helpful to those providers in states that are not pursuing Syndromic Surveillance electronic submission. We request that definitions of standards for data sharing be clarified as well as source of data. Could a provider use a data warehouse, which receives its data from the CEHRT, but is not certified to submit electronic case reporting or registry data? For the proposed objectives, CHA recommends:</th>
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- EHs and EPs should be allowed to utilize transmission methods that are supported by the registries accepting the data. The methods for registries to accept data varies greatly. As a result, the EH or EP should have the flexibility to determine the appropriate method of transmission to the registries accepting the data. |
immunization forecasts and histories from the public health immunization registry/immunization system (IIS). **Finalized as proposed.**

**Measure 2 finalized as – Syndromic Surveillance Reporting:** The EP, EH, 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 EHs or CAHs.

**Measure 3 – Case Reporting:** The EP, EH, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. This is a new reporting option. **Finalized as proposed.**

**Measure 4 – Public Health Registry Reporting:** The EP, EH, or CAH is in active engagement with a public health agency to submit data to public health registries. **Finalized as proposed.**

**Measure 5 – Clinical Data Registry Reporting:** The EP, EH, or CAH is in active engagement to submit data to a clinical data registry (e.g., The National Quality Registry Network). **Finalized as proposed.**

**Measure 6 – Electronic Reportable Laboratory Result Reporting:** The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results. **Finalized as proposed.**

- There needs to be exclusions for providers that do not have access to and/or organizational decisions have been made that limit participation in existing registries. Not all EPs – particularly specialists – have a relevant registry available to which they can submit data. An organization’s strategic plan may impact participation in certain registries. EPs should have the ability to align with their organization’s initiative.
- Similarly, not all hospitals have the capability to integrate or communicate with existing registries. There should be an exclusion for these hospitals.
- CMS provides (with updates) a list of nationally-identified registries. CMS could serve as a resource for identifying available registries.

CHA has some concerns with CMS’s proposal that an exclusion for the Public Health and Clinical Data Registry Reporting measure does not count toward the total of the measure. Similar to the other proposed objective measures, if any of the Public Health and Clinical Data Registry Reporting measures include an option for exclusion, an EH or EP should be permitted to attest to the exclusion and have it count toward the total of four EH measures or three EP measures. For example, if an EP is actively engaged with an immunization registry, but has not administered any immunizations during the EHR reporting period, then the EP should be permitted to take the exclusion option for the immunization measure and it should count towards their total of three EP measures. In this example, the provider has met the CMS goal to “further advance communication between providers and PHAs or CDRs, as well as strengthen the capture and transmission of such health information within the care continuum.” The EP should not be penalized for attesting to the appropriate exclusion. Furthermore, this exclusion scenario may be seen often in the 90-day reporting periods in 2015 and in first year MU providers under the Medicaid EHR incentive program.

In addition, there may not be a public health registry and/or the clinical registry for specialists. If registries are not available then there should be an exclusion for them.

**Proposed Measure 1**

In general, CHA supports bi-directionality but CMS must address standardization and capacity needs. Currently, many states are unable to conduct bi-directional exchange of information. This is a result of the lack of standard formatting requirements and a required set of data elements. CMS is finalizing the measure with the modification that a provider’s health IT system may still successfully meet this measure by layering additional information on the immunization history and forecasting.