Pharmacy Health Information Technology Collaborative

**Via Electronic Submission to: http://www.regulations.gov**

June 15, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3311-P
7500 Security Boulevard
Baltimore, MD 21244

**Re: CMS-3311-P – Medicare and Medicaid Program; Electronic Health Record Incentive Program – Modification to Meaningful Use in 2015 through 2017**

Dear Sir/Madam:

On behalf of the membership of the Pharmacy Health Information Technology Collaborative (Collaborative), we are pleased to submit comments in response to your Request for Comment for *Medicare and Medicaid Program; Electronic Health Record Incentive Program – Modification to Meaningful Use in 2015 through 2017.*

The Collaborative is supportive of the proposed modifications. Although pharmacists are ineligible for electronic health record (EHR) incentives, they will need to exchange information with EHR systems to connect to and ensure needed bidirectional communication with eligible professionals (EPs). Pharmacists provide patient-centered care and services, and as part of the integrated health care team, they are directly involved with patients in various practice settings, particularly with a patient's medication action plan. Pharmacists have standards in place to meet Stage 3 requirements.

The following are our comments regarding CMS-3311-P: *Electronic Health Record Incentive Program – Modification to Meaningful Use in 2015 through 2017.*

**Changes to Definitions for 2015 through 2017**
**(1) Stages of Meaningful Use (page 34)**

The Collaborative supports allowing providers the option to demonstrate Stage 3 beginning in 2017 as discussed in the Stage 3 proposed rule rather than starting Stage 3 in 2018 without the 2017 option.

**(a) Calendar Year Reporting Beginning in 2015 (page 36)**

The Collaborative supports changing the reporting period to a calendar year beginning in 2016.

**(b) 90-Day EHR Reporting Period for all Providers in 2015 (page 38)**

The Collaborative supports the option for allowing eligible professionals to select an EHR reporting period of a continuous 90-day period from January 1 – December 31, 2015. We also support a continuous 90-day reporting period between January 1-December 31, 2016 for eligible professionals, eligible hospitals, and CAHs that have not successfully demonstrated meaningful use in the prior year and are first-time participants in the program.

**Definition of Meaningful Use**
**(1) Considerations in Defining Meaningful Use (page 39)**

Although removing duplicative, redundant, or topped out measures would make sense, there appear to be some measures listed in Table 3 that are proposed to be removed, such as clinical summaries, structured lab results, and eMAR, that are valuable to providers and patients. The Collaborative requests that consideration be given to continuing to require providers to attest to the results of these specific measures. Not requiring that they be attested could result in unintended consequences and be perceived as a removal of endorsement, though this is not what may be intended.

**(a) Structural Requirements of Meaningful Use in 2015 through 2017 (page 43)**

The Collaborative supports eliminating the distinction between core and menu objectives and that all retained objectives and measures would be required for the program, especially the Stage 1 Menu: Perform Medication Reconciliation; Stage 1 Menu: Public Health Reporting; and Stage 2 Menu Eligible Hospitals and CAHs Only: Electronic Prescribing.

Additionally, the Collaborative supports allowing providers to continue to demonstrate Stage 1 of meaningful use in 2015 for Stage 2 objectives and measures for 2015 through 2017, particularly for e-prescribing.

**Changes to Patient Engagement Requirements for 2015 through 2017**
**Patient Action to View, Download, or Transmit Health Information (page 49)**

The Collaborative requests that CMS clarify its rationale for proposing to remove the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access (VDT) objective and requiring that at least one patient seen by a provider, eligible hospital, or CAH during the EHR reporting period, views, downloads, or transmits his or

her health information to a third party. This appears to be not advancing the use of EHRs by a patient while still providing incentives. We do not believe this would demonstrate that the capability is fully enabled and is being used.

**Secure Electronic Messaging Using CEHRT (page 50)**

The Collaborative does not believe that converting the measure for Stage 2 EP Secure Electronic Messaging objective from the 5 percent threshold to a yes/no attestation to the statement – "The capability for patients to send and receive a secure electronic message was enabled during the EHR reporting period" – advances the intent of the EHR incentive program. Without a minimum threshold to benchmark against, there would not be a way to show that the capability is enabled and is being used.

**Protecting Electronic Health Information (page 51)**

The Collaborative supports the proposed measure to protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical standards. The Collaborative also supports the proposed measure to conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of data stored in certified EHR technology, implement security updates as necessary, and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process.

**Clinical Decision Support** (page 53)

The Collaborative supports retaining the Stage 2 objective and measures for clinical decision support (CDS) for meaningful use in 2015 through 2017. We also support the proposed objective and measures to use CDS to improve performance on high-priority health conditions.

**Computerized Provider Order Entry (CPOE)(page 55)**

The Collaborative supports retaining the Stage 2 objective and measures for CPOE for meaningful use in 2015 through 2017 as unchanged.

**Electronic Prescribing (page 60)**

The Collaborative supports retaining the Stage 2 objective and measures for electronic prescribing for meaningful use in 2015 through 2017.

**Summary of Care (page 66)**

The Collaborative supports retaining the Stage 2 objective and measures for summary of care for meaningful use in 2015 through 2017.

**Patient Specific Education (page 69)**

The Collaborative supports retaining the Stage 2 objective and measures for patient specific education for meaningful use in 2015 through 2017.

**Medication Reconciliation (page 72)**

The Collaborative supports retaining the Stage 2 objective and measures for medication reconciliation for meaningful use in 2015 through 2017.

**Patient Electronic Access (VDT) (page 75)**

The Collaborative supports retaining the Stage 2 objective and Measure 1 for medication reconciliation for meaningful use in 2015 through 2017 without modification.

As noted in our previous comment, the Collaborative requests that CMS clarify its rationale for proposing to remove the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access (VDT) objective and requiring that at least one patient seen by a provider, eligible hospital, or CAH during the EHR reporting period views, downloads, or transmits his or her health information to a third party. This appears to be taking a step backward and not advancing the use of EHRs by a patient while still providing incentives. We do not believe this would demonstrate the capability is fully enabled.

**Secure Electronic Messaging (page 82)**

The Collaborative supports retaining the Stage 2 objective and measure for medication reconciliation with modification (claiming an exclusion) for meaningful use in 2015 through 2017.

**Public Health and Clinical Data Registry (CDR) Reporting (page 85)**

The Collaborative supports adopting the consolidated Stage 3 version of the public health reporting objectives for all providers to demonstrate meaningful use for an EHR reporting period in 2015 through 2017. The Collaborative especially supports the adoption of Measure 1: Immunization Registry Reporting; Measure 2: Syndromic Surveillance Reporting; Measure 4: Public Health Registry Reporting; and Measure 5: Clinical Data Registry Reporting.

As noted in our recently submitted May 29, 2015, Stage 3 comments to CMS, although the ONC is proposing to adopt a bidirectional exchange standard for reporting to immunization registries/IIS, which the Collaborative supported in its comments to the ONC, we would strongly encourage CMS to adopt and require similar bidirectional exchange of immunization information for pharmacies for this objective as well.

Pharmacists are readily accessible providers of immunizations throughout the United States. As such, pharmacists document vaccine contraindications and the reasons for vaccine refusals. Because of their frequent access to patients, pharmacists are in the position to capture immunization, cancer, hypertension, and diabetes information and submit to public health agencies and other registries in accordance with applicable laws. The Collaborative is working with structured documents, using C-CDA to electronically exchange immunization information with EHRs, which includes contraindications and substance refusals.

The Collaborative supports electronic data submission to immunizations registries and believes they can be effective tools to promote patient and population health; however, because such registries are maintained at the state and local levels through public health agencies, there needs to be a uniform standard for reporting. We would encourage the support and harmonization of standards, such as the HL7 and NCPDP (SCRIPT and Telecom) standards for this area. This would not only encourage EPs, hospitals, and CAHs to submit electronically and uniformly, but it would also afford uniform reporting opportunities for non-EPs, especially pharmacists, who are administering immunizations. The American Pharmacists Association reports that there are 260,000 pharmacists, including student pharmacists, trained to administer immunizations.

**Medicaid EHR Incentive Program in 2015 through 2017 (page 108)**

The Collaborative requests that CMS provide further explanation regarding the flexibility it plans to give states regarding public health reporting under the Medicaid EHR Incentive Program. CMS proposes to allow states to "change the public health reporting objective and measures as long as it does not require EHR functionality above and beyond that which is included in 45 CFR Part 170." Our concern is that allowing states to change the public health reporting objective and measures could lead to different objectives and measures in each state rather than a consistent, standard approach for all 50 states as is the goal of establishing a nationwide framework through the ONC.

Although pharmacists are ineligible for EHR incentives under the program, they are meaningful users of EHR and health IT and report to state registries, as noted in our comments above for Public Health and Clinical Data Reporting.

**Clinical Quality Measurement (CQM) (page 109)**

The Collaborative supports maintaining the existing requirements established for the reporting of CQMs for meaningful use in 2015 through 2017.

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The Pharmacy HIT Collaborative's vision and mission are to assure the nation's health care system is supported by meaningful use of HIT, the integration of pharmacists for the provision of quality patient care, and to advocate and educate key stakeholders regarding the meaningful use of HIT and the inclusion of pharmacists within a technology-enabled integrated health care system. The Collaborative was formed in the fall of 2010 by nine pharmacy professional associations, representing 250,000 members, and also includes eight associate members from other pharmacy-related organizations. The Pharmacy HIT Collaborative's founding organizations represent pharmacists in all patient care settings and other facets of pharmacy, including pharmacy education and pharmacy education accreditation. The Collaborative's Associate Members represent e-prescribing and health information networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. For additional information, visit www.pharmacyhit.org

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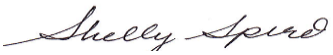
On behalf of the Pharmacy HIT Collaborative, thank you again for the opportunity to comment on the Request for Comment for *Medicare and Medicaid Program; Electronic Health Record Incentive Program – Modification to Meaningful Use in 2015 through 2017.*

For more information, contact Shelly Spiro, Executive Director, Pharmacy HIT Collaborative, at shelly@pharmacyhit.org.

Respectfully submitted,



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