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December 11, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS-3310 & 3311-FC, Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 through 2017 Final Rule with Comment Period, Oct. 15, 2015.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the final rule for the Centers for Medicare & Medicaid Services' (CMS) Electronic Health Record (EHR) Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 through 2017.

Hospitals strongly support the use of EHRs and other technology to support our shared goals of better coordinated, value-based care, and they have been working diligently to implement new health information technology (IT) to improve the coordination, quality and safety of care for patients. However, the complexity of the EHR Incentive Program has required excessive spending and focus on meeting meaningful use criteria; resources that could be better spent on patient care. **The AHA urges CMS to revise the EHR Incentive Program framework to reflect program experience to date, provide flexibility in the program measures so that providers can use certified EHRs to support high-quality clinical care and patient engagement, and delay new program requirements until the standards and infrastructure supporting the exchange of health information are mature.**

To reach the goal of EHR adoption and use across a sizeable majority of eligible hospitals (EHs), critical access hospitals (CAHs) and eligible professionals (EPs), the EHR Incentive Program framework and timeframe must be reoriented to provide operational and strategic flexibility for participating providers to enable them to achieve our shared national vision of an e-enabled health care system.

This letter provides the AHA's recommendations on how to improve the structure of the EHR Incentive Program, increase flexibility to ensure program success, and base meaningful use requirements on mature standards. The attached table provides detailed comments on the Stage 3 objectives and measures.

REVISE THE PROGRAM FRAMEWORK TO REFLECT EXPERIENCE TO DATE

The following recommendations would create a structure for meaningful use that supports program success.

Allow a reporting period of any 90 consecutive days in the first year of a new stage of meaningful use. **The AHA recommends that a 90-day reporting period be available for the first year of Stage 3 and any subsequent stages, and whenever there are changes to the definition of certified EHR, including a new edition of technology or new functionality**. Experience to date indicates that the transition to new editions of certified EHRs is challenging due to lack of vendor readiness, the necessity to update other systems to support the new data requirements, the mandate to use immature standards, an insufficient information exchange infrastructure and a timeline that is too compressed to support successful change management. A 90-day reporting period would give providers additional time to meet these challenges.

Postpone the required start of Stage 3 until a date no sooner than 2019. The AHA recommends that CMS refrain from increasing EHR Incentive Program complexity until the vast majority of eligible providers have attained the current stage. **Specifically, the AHA recommends that providers not be required to begin Stage 3 until at least 75 percent of EHs, 75 percent of CAHs and 75 percent of EPs have met Stage 2. A requirement to start Stage 3 should not occur in advance of the start of the new physician Merit-based Incentive Payment System (MIPS) and Advanced Payment Model (APM), currently scheduled to begin in 2019. The voluntary start of Stage 3 could be available in 2018.**

EHR adoption rates among hospitals have increased steadily since the program began in 2011; however, according to data from CMS, fewer than 40 percent of hospitals attested to Stage 2 meaningful use readiness in 2014. According to a recent study, 67 percent of hospitals that had not yet met a proxy for Stage 2 in 2014 cited the ongoing costs of technology adoption as a challenge, while 57 percent cited the complexity of meeting meaningful use criteria.[1]

Additionally, the disparity in EHR adoption rates persists, as evidenced by a gap of more than 10 percent between small and large hospitals in adoption of at least a basic EHR.[2] More than half of hospitals reported challenges related to financial costs.[3] The requirement to meet full year regulatory requirements and ongoing technology upgrades while the program moves from

[1] Adler-Milstein et.al., *Electronic Health Record Adoption in US Hospitals: Progress Continues, But Challenges Persist,* Health Affairs, Nov. 2015.
[2] Ibid.
[3] Ibid.

incentives to payment penalties could create even greater challenges for resource-constrained hospitals.

Moreover, failure to successfully attest to meaningful use results in annual negative payment adjustments. The reduction in Medicare reimbursement for those that do not meet meaningful use objectives is 1.2 percent for 2016, and will be higher in 2017 and later years. All providers require sufficient time to implement and upgrade technology and optimize performance before moving to more complex requirements for use.

Eliminate the all-or-nothing approach in meaningful use. The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act (ARRA) of 2009, defines a meaningful EHR user as an EH, CAH and EP that demonstrates to the satisfaction of the Secretary of Health and Human Services (HHS) during the reporting period: the use of certified EHR technology in a meaningful manner; that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; and that it submits information for the reporting period, in a form and manner specified by the Secretary, on clinical quality measures and such other measures as selected by the Secretary. CMS states that the statute does not permit a change to the all-or-nothing approach and requires more stringent measures of meaningful use to improve the use of EHRs and health care quality over time. We disagree and believe that the inclusion of more stringent measures does not prevent changes to the number of objectives and measures required to meet the program requirements. The AHA urges CMS to adopt an alternate approach that advances widespread health information technology (IT) adoption by all EHs, CAHs and EPs and sets requirements that are achievable and practical. Specifically, **the AHA recommends that EHs, CAHs and EPs that attest to meeting 70 percent of the meaningful use requirements be designated as having met meaningful use.**

Provide an attestation period of sufficient length to accommodate all EHs, CAHs and EPs that will attest simultaneously. The AHA is concerned that the 60-day attestation timeframe is too short to accommodate the simultaneous attestations by as many as 665,000 EHs, CAHs and EPs. In previous years, CMS's system has not been able to accommodate all those seeking to attest in an efficient manner. Indeed, as a result, CMS has extended the attestation period in the past due to these issues. Given past experience, we are concerned that the site will be overwhelmed and providers will not be able to attest by the deadline. **Therefore, the AHA recommends an attestation period of 120 days following the end of the reporting period, beginning in spring 2016**.

Provider experience in the EHR Incentive Program should inform future definitions of meaningful use. Stage 1 of meaningful use required program participants to electronically capture health information. Stage 2 requires program participants to electronically access and exchange health information with patients and other clinicians. With 40 percent of EHs and about 10 percent of EPs able to attest to Stage 2 in 2014, **the AHA recommends that CMS allow time for additional providers to attest to Stage 2, commission an independent study of the experience with Stage 2 and use the findings to inform Stage 3 requirements.** Additionally, we recommend that CMS study the experience and lessons learned from health

reform initiatives and new health care models that incentivize care coordination to provide insight on advanced uses of health IT in support of better health outcomes for patients, better health for populations and improved cost containment.

PROVIDE FLEXIBILITY IN PROGRAM REQUIREMENTS

The following recommendations would give providers the flexibility they need to meet meaningful use while pursuing our shared goals of better-coordinated, value-based care.

Focus on the availability of mature functionality in certified EHRs rather than thresholds that count the use of functionality. In the modifications rule 2015-2017, CMS revised the measure of patient engagement with the certified EHR to focus on the availability of functionality to share information with patients rather than counting how often the function was used. **Similarly, the AHA recommends CMS modify requirements in Stage 3 to emphasize the availability of EHR functionality, rather than counting the number of times functionality is used.** This approach reduces measurement burden while ensuring capabilities are in place. We recommend this approach for the following Stage 3 objectives: clinical decision support (CDS), e-prescribing, patient electronic access to health information, and coordination of care through patient engagement

For example, the AHA recommends that CDS functionality in certified EHRs should be used by hospitals to focus on priority health conditions that map to their own quality improvement priorities, rather than specifically link use of CDS to a specified number of clinical quality measures. Similarly, the requirement to count the number of patients that receive electronic access to patient-specific education materials forces providers to focus resources on counting patients. Rather, providers should continue to utilize many tools – electronic and otherwise – to provide patients with health information in the format that is most relevant for each individual patient and easiest for the patient to access.

Provide a hardship exemption from meaningful use penalties for any EH, CAH or EP that changes vendors during a reporting period. In a September 2015 report on nonfederal efforts to help achieve health information interoperability, the Government Accountability Office found that one of several barriers to interoperability is the costs associated with achieving interoperability, such as interfaces and EHR customization.[4] The AHA estimates that, between 2010 and 2013, hospitals collectively spent $47 billion each year on IT. The expense of adopting, implementing and upgrading technology are ongoing, while the program demands certified EHRs support information exchange for a full performance period. Given these conditions, a decision to change vendors during a reporting period places providers in an untenable position. Providers should not be penalized if their vendor is unable to support them in meeting regulatory requirements. **The AHA recommends expanding the hardship exception categories to allow providers to change EHR vendors during a reporting period to meet their needs without the additional burden of a payment adjustment**.

[4] GAO-15-817, *Electronic Health Records: Nonfederal Efforts to Help Achieve Health Information Interoperability*, General Accountability Office, September 20015.

Ensure that any modifications to the program requirements apply uniformly for all participants. The modifications rule includes several changes to the EHR Incentive Program that aligned requirements for EHs and CAHs with those of EPs, including the shift to calendar year reporting, a common attestation period and the requirement to report the same objectives and measures. **The AHA recommends that CMS modifications to the definitions, structure and reporting requirement of the EHR Incentive Program for EHs and CAHs are aligned with requirements for EPs pursuant to the creation of MIPS.** This alignment is critical to ensuring the ability to share information and improve care coordination among providers across the continuum.

Provide flexibility in the measures to support patient engagement with their providers. The availability of mature standards and the opportunity to innovate will allow EHs and CAHs to identify ways to promote patient engagement. Patient portal usage will increase as the sites become more user-friendly and useful. The EHR Incentive Program requirements are not the sole pathway to advance electronic patient engagement. The most recent data from the 2015 Most Wired survey indicate that hospitals with more mature health IT are going beyond meaningful use Stage 2 requirements to find ways to engage their patients. For example, 63 percent of the Most Wired hospitals offer self-management for chronic conditions through the patient portal, and 67 percent can incorporate patient-generated data through the portal. **The AHA recommends that CMS allow time for optimization of existing EHRs to support insight on approaches to patient engagement before requiring prescriptive patient engagement measures**.

Additional flexibility in measures also will require a reconsideration of the applicability of measures intended to support patient engagement. In the Stage 3 final rule, CMS requires EHs and CAHs to use certified EHRs to send a secure message to a patient or in response to a secure message sent by a patient, and requires counting the secure messages in order to meet a specified threshold. **The AHA recommends that the secure messaging measure to support coordination of care through patient engagement be applicable to EPs only because patients typically engage with their physicians to coordinate their care**.

Postpone mandatory electronic reporting of electronic clinical quality measures (eCQMs). The AHA recommends that CMS allow time for EHs and CAHs to become experienced with electronic submission of eCQMs before requiring electronic submission of eCQMs for an entire reporting period in the EHR Incentive Program. Experience to date indicates that very few EHs and CAHs are electronically submitting eCQMs due to EHR inability to support accurate clinical quality reporting. We recommend that CMS use the experience of eCQM reporting in CMS quality programs to inform the requirements for eCQM reporting in Stage 3. Additionally, we recommend that CMS not impose requirements on providers that the certified EHRs are not required to support. Currently, EHRs are not required to support the reporting of all eCQMs. Providers must report on the eCQMs that the technology has been certified to support.

ADOPT PROGRAM REQUIREMENTS SUPPORTED BY MATURE INTEROPERABILITY STANDARDS AND INFRASTRUCTURE ONLY

The following recommendations would ensure that providers have the technical abilities and infrastructure available to make the program successful.

Mature standards must exist before providers are required by regulation to use them. The transition to new technology supporting Stage 2 has been a challenge for providers due to lack of vendor readiness, mandates to use untested standards, insufficient infrastructure to meet requirements to share information and compressed timelines. **The AHA recommends that CMS refrain from including requirements in regulation that providers use a standard or functionality in certified EHRs in advance of evidence that the standard or functionality is ready for nationwide use.**

For example, it is premature to require that providers use Application Programming Interfaces (APIs) in the EHR to make health information accessible by any application (app) that requests to access to the information. Although the Office of the National Coordinator for Health Information Technology (ONC) finalized three certification criteria in support of APIs in the 2015 Edition Certification Rule, ONC specifically did not recognize a standard for APIs, citing standards immaturity. Additionally, ONC finalized the API requirements without specifying a certification approach or framework applicable to the apps that would extract data from the EHR.

Requirements to use new functionality such as APIs must be accompanied by standards that are mature, rigorously tested and are accompanied by implementation guidance that minimizes variation in the interpretation of the standard. Providers should not be required to use APIs that have not been certified by ONC, nor should they be required to share protected health information with apps that have not been certified by ONC. Furthermore, given the sensitive nature of health information, HHS should require all app developers to abide by HIPAA privacy and security rules, whether or not they are covered entities. In a Privacy Rights Clearinghouse study of mobile health and fitness applications, 43 percent of free applications were found to share user-generated personally identifiable information with advertisers and 43 percent of the apps had a link to the website's privacy policy.[5] CMS should work with ONC to include a requirement in the certification criteria to address this gap in privacy and security protections.

Robust testing and implementation guidance of mature standards must precede requirements for provider use. The experience using the consolidated clinical data architecture (C-CDA) standard to exchange summary of care records illustrates the problems with using standards that have not been adequately specified. Hospitals that receive summary of care documents find they are too large and it is difficult to find what is relevant and pertinent. For example, for patients that require hospitalization: the patient record is managed by a provider who will send a summary of care record to the hospital; the hospital will send a summary of care record back to the provider upon discharge; and the provider will receive a record with all laboratory results (current and historic), imaging results and medications during the patient stay – a large amount of information that is unlikely to indicate the most pertinent information that will support ongoing management of the patient. This challenge has been acknowledged by providers, vendors and the government. The creator of the C-CDA standard, HL7, is working to improve the C-CDA to make it more

[5] *Fact Sheet 39: Mobile Health and Fitness Apps: What Are the Privacy Risks*, Privacy Rights Clearinghouse, revised December 2014.

flexible so that all information can be exchanged and relevant information can be presented in an accessible manner, but that work is ongoing and has not been tested in real-world settings. Therefore, **the AHA recommends that CMS keep the threshold for sharing summary of care documents at the modified Stage 2 level of 10 percent in Stage 3.**

Focus on advancing interoperability. The AHA recommends that CMS focus on accelerating the exchange of data that is currently collected instead of including requirements to collect new data. Prioritization of use cases that accelerate the exchange of the current meaningful use data set that is being captured to support care will build confidence and support for tackling the capture and exchange of additional data elements. For example, the transition to the unique device identifier (UDI) has just begun and will not be complete until 2020. It will be a complex transition, as there are three separate agencies that use different standards to create the UDI, which can be as long as 75 characters. In addition to accommodating multiple UDI formats, EHRs also will need to accept the data from different forms of automated ID technology (such as a barcode or radio frequency identification tag). At the same time, hospitals are learning how best to use the UDI and change operations to accommodate it. The AHA supports the deployment of the UDI because of the safety and efficiency benefits it will bring. However, working through the standards development and implementation issues to support effective use of the UDI is a precursor to including the UDI as a data element in the common clinical data set. Given the significant investments made to date, the current certified EHRs must be a starting point for efforts to improve interoperability. The development and growth of new models of care are incentivizing information sharing by providers. **The AHA urges CMS to allow the current market pressures for information exchange from consumers and from new care delivery models to accelerate demand for information exchange.**

While the demand for information exchange grows, **the AHA urges CMS to work with federal agencies to prioritize the development of a patient identifier**. Providers are experiencing challenges in identifying patients and matching them to their medical records. The nation lacks a single national mechanism for identifying individuals such as a unique patient identifier. A single solution that would match individuals across IT systems would allow providers to know with confidence that a patient being treated in an emergency department is the same patient that a physician in another location diagnosed with an acute or chronic health condition that requires ongoing management. Patient safety concerns arise when data are incorrectly matched, such as a patient's current medication not being listed in the medical record or the wrong medications are included in the record. Stage 3 includes a measure requiring a clinical information reconciliation that includes medications, medication allergy and current problem list for more than 80 percent of transitions or referrals in which the provider has never before encountered the patient. This requirement would be easier to achieve with advancement of a patient matching solution.

The ability to optimize the functionality of certified EHRs is equally important to the ability to use the EHRs in the delivery of safe and quality health care. During the October 2015 joint meeting of the Health IT Policy and Health IT Standards Committees, a committee member recounted the experience of nurses in a hospital taking two hours to complete the documentation for the nursing admission assessment. Two hours were required for the task due to the number of places in the record where information was requested and the 537 clicks required to enter the data. The AHA recommends that CMS allow time for the evolution and maturation of EHRs so

that they support providers with more nimble solutions supporting the time-sensitive and high-reliability environment in which they are used.

America's hospitals are working toward a health care system where all providers are meaningfully using certified EHRs to improve patient care and safety as well as achieve national goals for improvement in the care of patients and populations. The AHA believes the recommendations presented in this letter will fulfill the goals of the ARRA legislation to create a constructive and positive pathway for nationwide adoption of EHRs. We believe the focus on increased EHR adoption and on interoperability will ensure that EHRs and other health IT tools can enable the efficient sharing of health information in support of care delivery, patient engagement and new models of care.

Thank you again for the opportunity to comment. If you have any questions, please contact me or Diane Jones, senior associate director of policy, at (202) 626-2305 or djones@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Attachment

Appendix A. AHA Detailed Comments on the Stage 3 Objectives and Measures

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
Protect electronic health information	Measure: 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 electronic protected health information created or maintained in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EH's or CAH's risk management process.	Protect electronic health information: Protect electronic protected health information created or maintained by the certified electronic health record technology (certified EHR) through the implementation of appropriate technical, administrative, and physical safeguards.	Conduct or review a security risk analysis per Health Information Portability and Accountability Act (HIPAA), including assessing the security (including encryption) of data created or maintained by certified EHR) 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 EH's or CAH's risk management process.	The AHA supports retaining the measure as finalized for Stage 3.
e-Prescribing	Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.	Electronic prescribing: Eligible hospitals (EHs and CAHs must generate and transmit permissible discharge prescriptions electronically (eRx).	More than 25 percent of EH or CAH discharge medication orders for permissible prescriptions (new and changed) are queried for a drug formulary and transmitted electronically using certified EHR.	Hospitals should only be required to attest that they are using e-prescribing at discharge. The AHA opposes a threshold that is more than 10 percent. Hospitals are required to report e-prescribing for the first time in Modified Stage 2 and require time to address the technology upgrades, interfaces with other systems and workflow modifications necessary to support this required measure.
Clinical decision support (CDS)	1: Implement five CDS interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EH's or CAH's scope of practice or patient population, the CDS	Clinical decision support (CDS): Implement CDS interventions focused on improving performance on high-priority health conditions.	Measure 1. Implement five CDS interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Measure 2. Enable and implement the functionality for drug-drug and drug-	The AHA recommends removing the tie between CDS and clinical quality measures in favor of high-priority safety and quality improvement objectives of the hospital. This would allow hospitals to determine how to use their EHR to meet quality improvement goals and it

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
	interventions must be related to high-priority health conditions. 2: The EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.		allergy interaction checks for the entire EHR reporting period.	would remove the measurement burden of tracking the links between CDS and clinical quality measures. The AHA recommends removing the "entire EHR reporting period" from the measure specifications to limit unnecessary measurement burden.
Computerized provider order entry (CPOE)	1: More than 60 percent of medication orders created by authorized providers of the EH's or CAH's inpatient or emergency department place of service ((POS) 21 or 23)) during the EHR reporting period are recorded using CPOE. 2: More than 30 percent of laboratory orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. 3: More than 30 percent of radiology orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	Computerized Provider Order Entry (CPOE): Use CPOE for medication, laboratory, and diagnostic imaging orders.	Measure 1. CPOE for medication - more than 60 percent of medication orders created by authorized providers of the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. Measure 2. CPOE for labs - more than 60 percent of laboratory orders created by the authorized providers of the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. Measure 3. CPOE for diagnostic imaging – more than 60 percent of diagnostic imaging orders created by the authorized providers of the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	The AHA recommends the continuation of the three measures with thresholds in the published Stage 3 final rule. AHA also recommends that CMS not increase the thresholds above 60 percent. The AHA recommends that CMS clarify the provider that may claim attribution for the order.
Patient-specific education	More than 10 percent of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific	Patient electronic access to health information: Use the certified EHR functionality to provide patient	Measure 1. For more than 80 percent of unique patients, either: (i) the patient (or patient-authorized representative) is provided timely access	Measure 1. The AHA opposes the requirement to use API functionality for patient engagement for educational resources or for health information

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
	education resources identified by Certified EHR Technology.	access health information or patient-specific educational resources.	to view online, download, and transmit their health information - and (ii) the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's certified EHR. Measure 2. Use certified EHR to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients.	exchange through patient engagement in advance of a mature standard and certification of patient-selected applications. The AHA opposes the requirement to make patient health information available within 36 hours of its availability to the provider for an eligible hospital or CAH through an API of the patient's choice as it would present operational challenges to hospitals. We support continuation of making information available to view, download or transmit. Measure 2. The AHA opposes the use of a specific threshold to monitor electronic access to patient specific educational resources due to the absence of studies that indicate an appropriate threshold for all providers. In the absence of evidence, the AHA recommends CMS focus on the functionality in the EHR and commission a study that evaluates provider experience with use and optimization of the functionality. We also recommend that CMS provide clarity on how the EH, CAH or EP would discern that the patient-specific educational resources are actually generated by the certified EHR.

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
Patient electronic access (view, download and transmit)	1: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH are provided timely access to view online, download, and transmit to a third party their health information. 2. For 2015 and 2016: At least one patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or patient-authorized representative) views, downloads, or transmits to a third party his or her health information during the EHR reporting period. For 2017: More than 5 percent of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or patient-authorized representative) view, download, or transmit to a third party their health information during the EHR reporting period.	Coordination of Care through Patient Engagement: Use certified EHR functionality to engage with patients or their authorized representatives. EH and CAH must attest/report the numerators/denominators for all three measures and must meet thresholds for two out of three measures.	Measure 1. More than 10 percent of all unique patients (or their authorized representatives) 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. Measure to be met by patient is one of the following (i) view, download, or transmit to a third parity their health information, (ii) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's certified a combination of (i) and (ii). Measure 2. For more than 25 percent of all unique patients or patient's authorized representative discharged from EH or CAH inpatient or emergency department (POS 21 or 23), certified EHR was used to send a secure message to the patient or used in response to a secure message sent by the patient. Measure 3. Patient generated data or data from a non-clinical setting is incorporated into the certified EHR for more than 5 percent of all unique patients.	Measure 1. The AHA opposes the requirement to use API functionality for patient engagement with a EH's or CAH's EHR in advance of a mature standard and certification of patient-selected applications. The AHA opposes the use of a specific threshold to monitor patient active engagement with the EHR and recommends the continuation of the Modified Stage 2 approach for measure 1 that focuses on the availability of functionality in the EHR to support the objective. A study and evaluation of provider experience with use and optimization of the functionality will inform future requirements such as what or if thresholds are necessary. Measure 2: The AHA recommends that the secure messaging measure be applicable only to EPs as a patient is more likely to seek information from a primary care provider following an acute care visit rather than contacting the hospital directly. In addition, we believe it is appropriate to measure the provider's use of the secure messaging but not the patient's responsiveness or utilization of this technology. If EH/CAH use of secure messaging is included, CMS should only require that functionality is enabled.

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
				Measure 3. The AHA believes it is premature to finalize a requirement that providers use certified EHR functionality to support receipt of patient-generated data or data from non-clinical settings from 15 percent of all unique patients. The AHA recommends that CMS study the experience of hospitals that are using the patient generated data to inform this regulatory proposal.
Summary of care	Measure: The EH or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses Certified EHR Technology to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	Health information exchange: provide a summary of care record when transitioning or referring their patient to another setting of care, or retrieve a summary of care record upon the first patient encounter with a new patient. EH/CAH must attest/report the numerators/denominators for all three measures. Must meet threshold on two of three measures.	Measure 1. For more than 50 percent of transitions of care and referrals, a summary of care record is created and sent electronically. Measure 2. For more than 40 percent of transitions and referrals received and patient encounters in which the provider has never before encountered the patient, incorporate into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system. 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 EH, CAH or EP performs a clinical information reconciliation that includes medications, medication allergy, and current problem list.	Measure 1: The AHA recommends retaining the modified Stage 2 threshold that EHs and CAHs use their certified EHR to create and electronically send a summary of care for more than 10 percent of transitions of for summary of care. There is no evidence that the 50 percent threshold is attainable. The AHA also recommends that CMS allow access to a shared record to count for purposes of Measure 1. The use of health information exchanges to make information available to exchange participants also should count in the fulfillment of Measure 1. Measure 3: The AHA strongly opposes the 80 percent threshold for medical record information reconciliation for new patients. This requirement precedes the readiness of patient matching solutions

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
				and the availability of EHR interoperability that supports the exchange and use of accurate health information within a recipient's EHR without manual effort.
Medication reconciliation	The EH or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23).	Not included as a separate objective in Stage 3		
Public health	Measure 1. Immunization Registry Reporting: The EH 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. Measure 2. Syndromic Surveillance Reporting: The EH or CAH is in active engagement with a public health agency to submit syndromic surveillance data from an emergency or urgent care department for EHs and CAHs (POS 23). 3. Specialized Registry Reporting: The EH or CAH is in active engagement with a public health agency to submit data to a specialized registry. Measure 4. Electronic Reportable Laboratory Result Reporting: The EH or CAH is in active engagement with a public	Public health and clinical data registry reporting: EH or CAH is in active engagement with a public health agency (PHA) or clinical data repository (CDR) to submit electronic public health data in a meaningful way using certified EHR, except where prohibited and in accordance with applicable law. EHs and CAHs must attest/report on four measures. The registry measures may be counted more than once if multiple registries are supported.	Measure 1. Immunization registry reporting. The EH or CAH is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). Measure 2. Syndromic surveillance reporting. The EH or CAH is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting. Measure 3. Case reporting. The EH or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure 4. Public health registry reporting. The EH or CAH is in active engagement with a public health agency to submit data to public health registries.	The AHA recommends retaining the modified Stage 2 requirement concerning the number of measures reported for this objective. EHs and CAHs should report on three of four measures. AHA recommends the retention of the modified Stage 2 specialized registry reporting option as one category that includes both the public health registry and clinical data registry. Case reporting can fit under the specialized registry reporting option, as it is in Modified Stage 2. CMS should not include separate categories for public health, clinical data, and case reporting registries. AHA recommends a requirement that registries that receive data from certified EHRs also must be subject to certification. AHA recommends the continued availability of the alternate exclusions to the

Final Rule Modified Stage 2 Objective	Final Rule Modified Stage 2 Measures	Final Rule Stage 3 Objective	Final Rule Stage 3 Measures	AHA Comments to Stage 3 Objectives and Measures, CMS-3310 & 3311-FC
	health agency to submit electronic reportable laboratory results.		Measure 5. Clinical data registry reporting. The EH or CAH is in active engagement to submit data to a clinical data registry. Measure 6. Electronic reportable lab results. The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.	measures in the public health reporting objective until the database of national, regional, state registries is available to facilitate the measure reporting requirement. AHA recommends that CMS continue efforts to support public health agencies in their ability to receive the data in accordance with the agreed upon standards.