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May 27, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3310-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted via www.regulations.gov

RE: CMS-3310-P [NPRM on Medicare and Medicaid Programs; Electronic Health Record Incentive Program, Stage 3]

To Whom It May Concern,

Bi-State Primary Care Association appreciates the opportunity to provide comments in response to the proposed rule regarding Medicare and Medicaid Electronic Health Records (EHR) Incentives Stage 3 Meaningful Use (MU) Criteria, which was published by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2015.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State works with federal, state and regional health policy organizations, foundations and payers to develop strategies, policies and programs that provide and support community-based primary health care services in medically-underserved areas. Our members include Community Health Centers, which include Federally Qualified Health Centers (FQHCs); Rural Health Clinics; private and hospital-supported primary care practices; Community Action Programs; Health Care for the Homeless programs; Area Health Education Centers; Clinics for the Uninsured, and social service agencies.

Bi-State is focusing its comments primarily on issues that are of particular importance to FQHCs in their efforts to ensure access to high quality, cost-effective, patient-centered care for medically-vulnerable patients and populations. In addition to our comments, we fully endorse the National Association of Community Health Center's letter that will be submitted before the deadline, as well as the Community Health Access Network's letter (New Hampshire's Health Center Controlled Network). Our letter parallels their comments and concerns. Below please find a summary of our high-level comments.

General Reporting Requirements:

1. Shorten the EHR reporting period for 2018 to 90 days.
2. For eligible providers who work at more than one location but meet MU at a single location where more than 50% of their encounters occur, reduce reporting burden by requiring them to report only on the one location.
3. Establish a national tracking mechanism by which Medicaid Eligible Professionals (EPs) who are affiliated with FQHCs can be distinguished from other Medicaid providers, and collect this data at the national level.

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Specific Objectives and Measures:

1. Protect Patient Health Information: Clarify that Security Risk Assessments (SRAs) are conducted by employers/organizations, rather than eligible providers.
2. Electronic Prescribing (eRx): Adjust the requirements that at least 80% of permissible prescriptions written by the EP be queried for a drug formulary and transmitted electronically using Certified ERH Technology (CEHRT).
3. Computerized Provider Order Entry (CPOE): Clarify the appropriate use of scribes to do CPOE, including permitting “Veteran Medical Assistants” to continue doing the same tasks they did prior to the introduction of CPOE requirements.
4. Patient Electronic Access to Health Information (AHI): Ensure that measures are attainable through CEHRT and do not require the purchase of add-on products; encourage the aggregation of individual patient’s data from multiple EPs into a single site; clarify which accounts are included in the numerator for this measure.
5. Patient Engagement:
 - Recognize the financial and linguistic challenges faced by FQHC patients, and reduce the degree to which EPs are held accountable for patient behavior that is beyond their control, by lowering the patient engagement thresholds from VDT (View, Download and Transmit) from 25% to 10%, secure messaging from 35% to 10%, and patient generating data from 15% to 5%.
 - Permit any EP who contributes to a secure patient message (not just the initiating EP) to count that patient in their Secure Messaging measure.
 - Reconsider the measure on incorporating patient-generated health data into the EHR.
6. Care Transitions and Referrals:
 - Continue the development of the Nationwide Health Information Network, and the alignment of efforts to advance this goal.
 - Ensure that all functionality required for MU is part of the core EHRT and not dependent on the purchase of third party add-on software packages, interfaces, etc.
7. Public Health and Clinical Data Registry Reporting:
 - Clarify that public health measures are to be met by the site, not the EP.
 - Finalize the use of the term “active engagement” in these measures.
 - Finalize proposals to create a centralized repository of national, state, and local PHA and CDR readiness, and to develop a national infrastructure to support more standardized reporting of measures such as immunizations.

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Thank you for the opportunity to comment on this Proposed Rule. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via e-mail at tkuenning@bistatepca.org if you require clarification on the comments presented above.

Sincerely,



Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer
Bi-State Primary Care Association