We greatly support CMS’ effort to reduce clinician burden within different regulatory programs. Most recently, with the change to the Merit-Based Incentive Payment within Quality Payment Program for 2019, there are discrepancies in both the objectives of measures but also within measures that share the same goal. This is most evident in the Promoting Interoperability Medicaid program versus Promoting Interoperability category of the Merit-Based Incentive Payment system.

It seems illogical if the focus in Quality Payment Program/Merit-Based Incentive Payment is now on Promoting Interoperability (as well as tackling the Opioid epidemic) that other measures which are not relevant to those goals are seeing huge threshold increases e.g. Clinical Reconciliation, Provide Patient Education, Patient Access Offer, and send a Summary Of Care in the Promoting Interoperability Medicaid program. Added to this there is a Patient Generated Health data measure which seems misguided in terms of the new Promoting Interoperability program objectives. Yet clinicians will be measured on these and must meet much higher thresholds, although the Hospitals they practice in no longer have these expectations as a result of the different measures proposed in the IPPS rule which impacts the Promoting Interoperability Hospital program. Although all these increases are incredibly difficult to meet, the Send a Summary of Care threshold is almost impossible to meet for certain healthcare providers individually or collectively. We propose CMS analyze the data for these measures for past years for those clinicians who did not have an exclusion for the measures to arrive at a more reasonable threshold.

The Bipartisan Budget Act of 2018 removed the mandate that meaningful use standards become more stringent over time, yet there is no current option for Eligible Providers in the State Electronic Health Record program to avoid the incredibly aggressive and burdensome thresholds set forth in Promoting Interoperability Medicaid Stage 3 for several measures which now are no longer CMS focus.

Added to the issue of separate Electronic Health Record measures in “Hospital” versus “Provider” programs, the thresholds for the very measures proposed for removal for Eligible Hospitals and CAHs increase exponentially in Stage 3 for Eligible Providers in the Promoting Interoperability Medicaid programs. Most of these measures are already difficult to meet in Stage 2, yet the thresholds for these measures increase by significant amounts, as noted below:

Clinical Reconciliation 50% > 80%

Patient-Specific Education 10% > 35%

Patient Access Offer 50% > 80%

Send a Summary of Care when transitioning a patient 10% > 50%

Patient Generated Data *(new measure)*  5%

There is no current regulatory option for clinicians in the Promoting Interoperability Medicaid programs to attest to Stage 2 Meaningful Use in 2019. **We strongly urge that consideration be given to the following alternatives**

1. An option for the States to continue to allow EPs to use the Stage 2 measures.
2. CMS clarify that States can adopt the new Promoting Interoperability objectives and measures from the Merit-Based Incentive Payment in the Promoting Interoperability Medicaid programs for Eligible Clinicians.
3. CMS revert the thresholds for all measures in Stage 3 back to the Stage 2 thresholds i.e.
	1. Clinical Reconciliation 50%
	2. Patient-Specific Education 10%
	3. Patient Access Offer 50%
	4. Send Summary of Care 10%
4. Analyze previous years data for these four measures and establish more realistic thresholds.

This would greatly reduce burden and allow clinicians to focus on measures they understand already rather than deal with different measures in three different programs e.g. Promoting Interoperability in MIPS, Promoting Interoperability for Hospitals and CAHs, and Promoting Interoperability Medicaid.

We support the change in scoring to reflect the new Promoting Interoperability objectives and scoring and applaud the effort to make the EH Electronic Health Record incentive program (now Promoting Interoperability) measures match those of the Promoting Interoperability category of MIPS. However as previously mentioned in our comments, we ask that CMS also make these same objectives and measures applicable to the Promoting Interoperability Medicaid (formerly EP Meaningful Use). As currently proposed through separate rules, many clinicians will be measured on totally different measures and objectives in MIPS (Promoting Interoperability category) and the Promoting Interoperability Medicaid. These increase burden greatly and causes conflicting areas of focus for care providers.

Lastly, we ask that CMS address an issue that highlights the inconsistency between different programs. In each of the 3 Promoting Interoperability programs the **Patient Electronic Access** measures calls for all health information to be made available to patients in a “timely” manner. However, in all 3 programs the definition of timely is different, see below

* Promoting Interoperability Hospital – 36 hours
* Promoting Interoperability Medicaid – 48 Hours
* Promoting Interoperability in Quality Payment Program 4 Business days

The goal of this measure is consistent across all 3 programs i.e. make patient’s health information easy to access in a timely manner. However, the different timeframes make it almost impossible to meet in each program because the same patient encounters have different definitions of timely. Because of this, the only feasible way to set up the release of test results (which are often very sensitive) for success in a single Electronic Health Record is to use the most aggressive definition/setting. This is very confusing as well as unnecessary and is likely an unintended consequence on CMS’ part. The outcome is that clinicians who set up their EHR to the most aggressive standard may not get to review results in 36 or 48 hours. This in turn means patient’s sensitive test results may be released to them before a clinician can discuss said results with them which may lead to patient harm.