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ALLIANCE
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July 21, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: Proposed Modifications to Medicare and Medicaid Electronic Health Record Incentive Programs for 2014

Dear Administrator Tavenner:

The six undersigned organizations represent a collaboration of leading consumer and purchaser organizations, committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment and quality improvement. We appreciate the opportunity to provide input on the proposed changes to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2014. The Meaningful Use and EHR Incentive Programs are foundational to ensuring that we have the health information technology infrastructure to meet the needs of health reform. Meaningful Use is inextricably tied to ongoing efforts to transform the health care delivery system to meet the National Quality Strategy goals of better outcomes, improved individual experiences of care, and reduced costs.

We acknowledge the rationale behind the Centers for Medicare & Medicaid Services' (CMS) and the Office of the National Coordinator for Health Information Technology's (ONC) proposal to adjust the program timeline. Nonetheless, consumers and purchasers oppose the proposal to slow down the implementation of Meaningful Use. We are dismayed that, once again, patients and purchasers would have to wait to realize many of the benefits of health IT, particularly the interoperability requirements and patient engagement criteria finalized for Stage 2 (such as the ability to view, download, or transmit health information, the opportunity to securely email providers, capturing family health history as structured data, and more). Any additional delay in building a robust electronic health information exchange would compromise efforts to achieve the goals of the National Quality Strategy. We see each stage in the Meaningful Use program as a crucial stepping stone toward addressing the incredibly fragmented system that consumers and purchasers face today, and improving not only care coordination and outcomes, but also patient safety and cost.

If CMS and ONC must make the proposed changes due to pressure from providers and EHR vendors, we expect a clear path to achieving the intended results of the 2014 Edition Certified EHR Technology

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(CEHRT) and Stage 3 of the Meaningful Use program by clarifying the reasons providers could use the outdated 2011 Edition CEHRT and strengthening the design and implementation of Stage 3 to meet consumers' and purchasers' needs.

Reporting Flexibility in 2014

We understand that some providers have been unable to fully implement 2014 Edition CEHRT due to delays in availability and final certification. While we support the intention of the Notice of Proposed Rulemaking (NPRM) to grant these providers necessary flexibility in order to participate in the 2014 reporting year, we oppose a blanket approach to offering flexibility to any participating provider. We strongly encourage CMS and ONC to require use of 2014 Edition CEHRT to the greatest degree possible. We request clarification below on what information or evidence providers would be required to submit to demonstrate that they were unable to fully implement 2014 Edition CEHRT when they attest to meaningful use.

We also understand that the stage and version of meaningful use measures depend upon the edition of CEHRT used by a provider. However, many of the Stage 2 and the 2014 Stage 1 objectives contain functionality that is essential to meaningful interoperability, and to patient engagement and partnership with their providers, such as the View/Download/Transmit (V/D/T) criterion. Consequently, those providers allowed to attest instead to the 2013 Stage 1 objectives for the 2014 reporting year would not have to provide patients with online access to their health information or hospital admission information. Providing patients with online access to their own health information was a monumental advancement for consumers, promised to be realized in the 2014 reporting year. Making patients and families wait longer for improved access to their own health information seems counter to the very concept of "meaningful use" of CEHRT.

Additionally, the proposed flexibility would further delay improvements in interoperability as many of the objectives designed to make progress on electronic exchange and use of health information are specific to Stage 2, such as the requirement to electronically exchange a Summary of Care record.

We recognize that developing and implementing 2014 Edition CEHRT is neither simple nor easy, and that many of the delays are successive. However, it is disappointing that consumers and purchasers would have to wait to realize some of the most game-changing benefits of health IT. The proposal would also delay achieving strategic goals Congress set forth in the HITECH Act. As Meaningful Use continues to be implemented, CMS and ONC must ensure that there are no recurrences of these difficulties and delays in the 2015 reporting year and beyond.

CMS and ONC should use any delay to learn from the on-the-ground implementation of Stage 2 in order to inform the development of Stage 3 policy and technical requirements. This is particularly critical given the number of patient engagement requirements that are part of Stage 2; patients and families deserve to have these criteria thoughtfully and effectively implemented. It is important to note,

however, that the proposed timeline adjustments to delay Stage 2 implementation would interrupt the feedback loop and make this learning more difficult.

Clarifying the Regulatory Amendment's Scope

The NPRM notes throughout the background discussion that CMS and ONC intend the proposed exception to using 2014 Edition CEHRT to reach only those providers "that are unable to fully implement 2014 Edition CEHRT because of issues related to 2014 Edition CEHRT availability delays." The proposed regulatory language itself, however, at 79 FR 29738, does not limit itself to only those providers who are unable to implement 2014 Edition CEHRT, and nowhere includes a definition of who would and who would not be permitted to delay compliance. Instead, as amended, it appears that all eligible professionals and hospitals would be permitted to delay compliance, because the proposed amendment shifts the requirement to use 2014 Edition CEHRT from "FY and CY 2014" to "FY and CY 2015" for the entire program, not just those unable to comply.

Consistent with the NPRM's articulated intention, any amendment to section 170.102 must instead limit the proposed change to those eligible professionals and hospitals which are unable to fully implement 2014 Edition CEHRT as required, and must include a definition of what qualifies as inability to implement 2014 Edition CEHRT. Conversely, this ensures that as many patients as possible continue to receive the benefits they could and should be receiving under Stage 2 in 2014.

Delaying Stage 3

We do not support the proposed delay of Stage 3 until 2017. Stage 3 is intended to leverage new capabilities to improve health outcomes and reduce health disparities. Delays in implementing the advanced functionalities in EHR systems associated with Stage 3 would further postpone better care quality and health outcomes. If CMS and ONC must implement a one-year delay of Stage 3, we urge you to use this additional time to strengthen the Meaningful Use program and ensure that Stage 3 is designed and implemented in ways that meet the needs of consumers and purchasers across the nation.

For example, we encourage CMS and ONC to revisit the recently withdrawn recommendation regarding patient reminders for preventive or follow-up care. Any delay should also be leveraged to make meaningful, robust advancements in the areas of patient-generated health data and person-centered care planning in Stage 3. Furthermore, there should be substantial improvement in Stage 3 criteria to reduce health disparities across the United States, including broadening access to health information and education materials in languages other than English.

The EHR Incentive Program offers a unique opportunity to advance the capabilities and uses of health IT in quality improvement. However, to date, health IT-enabled quality measurement has not produced the

results expected, in part because time and money were expended on developing low-value measures.[1] The Meaningful Use and EHR Incentive Programs must create a functional health IT *system* for managing and improving health care, rather than a constellation of separate health IT programs working in parallel but not in concert with each other. We advise doing this through targeted use of the best measures available and developing measures to fill gaps.

At a minimum the Meaningful Use and EHR Incentive Programs should require a limited set of already-existing high-value measures that leverage functionalities that are only possible in an electronic environment and that support new payment and delivery models. By focusing on high-value measures already applicable to electronic use —such as biometrics data to support risk adjustment, increasing the capacity for patient-reported outcomes (PROs), and measures that identify overuse of tests and procedures—and discarding low-value measures, it will target key areas for improvement. The current program has too many process measures that will not make a big difference in improving care (e.g., reflect basic competencies, mask outcomes, allow providers to simply check the box). We appreciate and support the effort to align Meaningful Use with other programs like PQRS, and encourage CMS and ONC to ensure that the quality measures required for these programs are high-value, actionable measures that are meaningful to providers as well as consumers and purchasers.

Although we advocate for adopting already-existing high-value measures, measure development is also necessary to fill certain gaps and demonstrate value of HIT in measuring and improving quality. The Meaningful Use program is uniquely positioned to play an important role in advancing the creation of more robust quality measures. We have offered suggestions about measure development and use in previous comments to you and to the HIT Policy Committee, and for additional guidance on measure development please see our *Ten Criteria for Meaningful and Usable Measures of Performance.*[2] We recommend that Stage 3 incorporate and support the development of important measures of patient safety, patient outcomes, cost and resource use, appropriateness of care, and patient engagement.

Importantly, for quality improvement programs to achieve their greatest potential, results must be fed directly to clinicians, as well as the necessary reporting entities, to drive the *use* of data for quality improvement.

In closing, on behalf of the millions of Americans represented by the undersigned organizations, we urge CMS and ONC to reconsider the proposed extension of 2011 Edition CEHRT reporting and delay of

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[1] For example, efforts to build measures of patient-reported outcomes for orthopedic care resulted in check-the-box measures of whether the clinician "assessed" the patient's functional status before and after hip and knee replacement. It failed to take advantage of more valuable measures and tools (e.g., Minnesota Community Measurement's patient-reported outcome measure for total knee replacement, NIH PROMIS).

[2] Consumer-Purchaser Disclosure Project, *Ten Criteria for Meaningful and Usable Measures of Performance*, September 2011, http://www.consumerpurchaser.org/docs/files/CP%20Alliance_10_Measure_Criteria.pdf.

Meaningful Use Stage 3. If these changes are implemented, we expect that CMS and ONC will use the additional time from a delay of Stage 3 to ensure the Meaningful Use and EHR Incentive Programs are as strong as possible, and include high-value, meaningful performance measures and functional requirements that are important to consumers and purchasers.

If you have any questions, please contact either of the Consumer-Purchaser Alliance's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,

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National Partnership for Women & Families
Pacific Business Group on Health
St. Louis Area Business Health Coalition
UNITE HERE HEALTH