

September 6, 2016

***Submitted Electronically***

The Honorable Sylvia Mathews Burwell  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Mr. Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

**Re: Electronic Health Record Incentive Program—Proposed Modifications to Stages 2 and 3 (CMS–1656-P)**

Dear Secretary Burwell and Administrator Slavitt:

The Consumer Partnership for eHealth (CPeH) and the undersigned 24 organizations and individuals submit these formal comments on the proposed amendments of regulations governing Stage 2 and Stage 3 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (“Meaningful Use”).<sup>1</sup> CPeH is a coalition of more than 50 leading consumer, patient and labor organizations working at national, state and local levels to advance health information technology (health IT) in ways that measurably improve the lives of individuals and families. The combined membership of CPeH represents more than 127 million Americans.

We appreciate the opportunity to comment on these proposed amendments. Consumers are eager to work with the Centers for Medicare & Medicaid Services (CMS) to leverage health IT and health information exchange to improve the quality and value of care, and ensure that new models of care delivery and payment provide consumers and their family caregivers access to well-coordinated, patient- and family-centered care.<sup>2</sup>

---

<sup>1</sup> The 24 organizations and members of the Consumer Partnership for eHealth, joined by others, who sign this letter do so jointly in one letter rather than send 24 separate letters. If CMS counts responses for any particular purpose, please count them as 24 responses, not just one response.

<sup>2</sup> For brevity, we refer throughout our comments to “patient” and “care,” given that many federal programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves

The proposed rule generally reduces Stage 3's thresholds back to Modified Stage 2 thresholds. We are perplexed that CMS proposes to abandon Stage 3 thresholds on the very objectives that it identifies as the "priority goals" – patient electronic access to health information, coordination of care through patient engagement, and health information exchange – in its recently proposed rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA).<sup>3</sup> HHS's national initiatives on delivery system reform cannot possibly succeed without active engagement of patients and family caregivers, and the ability to access and share health information online is a critical tool for so many.

CMS cites reducing hospital administrative burden and allowing hospitals to focus more on patient care as the rationale behind these proposed changes. Measures designed to give individuals access to critical health information and help them use it are not obstacles to, but rather enablers of, high-quality care. Online access significantly improves patients' knowledge of their health, ability to communicate with their doctors and correct errors in their medical records, and desire to do something to improve their health.<sup>4</sup> Far from being administrative burdens or inconveniences, these activities are integral to developing partnerships among patients, their family caregivers and their care team in the mutual pursuit of better care and improved health outcomes.

Providers remain one of the most trusted sources of information, and play a vital role in helping their patients understand what information is now easily accessible to them and how they can use it. Without relevant measures that hold providers accountable for a small percentage of their patients' accessing, using or sharing their health information, **CMS retreats from the activities that hold the most promise for improving the quality of care and health outcomes for patients.** Without sustained progress on these activities that promote information access and exchange among patients and providers, hospitals will not be prepared to meet the demands of new models of care delivery and payment that depend upon greater patient engagement and care coordination.

In the comments below, we urge CMS not to retreat to "one patient" for patient use of electronic access in Stage 2 in 2017. Furthermore, we recommend that CMS recommit to meaningful thresholds for critical measures of patient and family engagement and health information exchange for Stage 3 – particularly those in Objective 6 that hold the most promise for patient and family engagement, care coordination and health information exchange with patients. We

---

as "consumers" or merely "persons" (rather than patients). Similarly, the health care community uses the terminology "caregivers" and "care plans," while the independent living movement may refer to "peer support" and "integrated person-centered planning."

<sup>3</sup> Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, 81 Federal Register 28162, 28224 (May 9, 2016).

<sup>4</sup> National Partnership for Women & Families, Engaging Patients and Families: How Consumers Value and Use Health IT, p. 29 (Dec. 2014), available at <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>.

also urge CMS to preserve a modified clinical decision support (CDS) measure that promotes patient-facing uses of CDS, and to retain full-year reporting in 2016.

## Meaningful Use Measure Thresholds

We are concerned that CMS proposes to reduce previously finalized thresholds. Particularly for measures of online access, CMS’s attestation data for Stage 2 show that hospitals are successfully meeting or exceeding original thresholds for both Stages 2 and 3, thus calling into question the need for such drastic reduction.<sup>5</sup>

### Stage 2

Once again, CMS proposes to lower the threshold for patient use of electronic access to health information (View/Download/Transmit) to just “one patient” – this time for Stage 2 in 2017, thus extending the one-patient threshold for the entirety of Stage 2 in 2015-2017 (and the first year of Stage 3 in 2018). In effect, for patient access, hospitals need only “check the box” to fulfill a measure that could otherwise have a monumental impact on reshaping attitudes, behaviors and workflows to cement data access as a foundational strategy for consumer engagement. This sends the wrong signal to the nation’s patients and families, and to hospitals and clinicians, about CMS’s commitment to patient and family engagement as a cornerstone of delivery system reform.

The current minimum standard of five percent in 2017 signals a genuine expectation by CMS, and is meaningful enough to drive real progress in patient and family engagement. Five percent is also more than achievable, as CMS itself reports that median performance is 32 percent of patients for doctors and 11 percent of patients for hospitals on Stage 2’s measure of actual online access.<sup>6</sup> Furthermore, our national survey shows that 86 percent of patients with online access use it, and 55 percent use it at least three times per year.<sup>7</sup> Therefore, we strongly urge CMS to keep the View/Download/Transmit threshold at **5 percent** for 2017 and not backtrack again to “one patient.”

### Stage 3

CMS also proposes to abandon increased thresholds for the patient online access, care coordination through patient engagement, and health information exchange objectives, and

---

<sup>5</sup> Centers for Medicare & Medicaid Services, Medicare & Medicaid EHR Incentive Programs: HIT Policy Committee, October 6, 2015, pp. 4, 33-35, available at [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HITPC\\_October2015\\_Fulldeck.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HITPC_October2015_Fulldeck.pdf).

<sup>6</sup> Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3, 80 Federal Register 16732, 16756 (Mar. 30, 2015).

<sup>7</sup> Engaging Patients and Families: How Consumers Value and Use Health IT, supra note 4, p. 28.

instead keep Stage 3 measures at Stage 2 thresholds. **It is critical that CMS maintain robust, meaningful thresholds for key measures in Objectives 5, 6 and 7.**

**Objective 5:** We understand that new elements of the Patient Electronic Access measure in Stage 3 – namely the additional requirement to provide access through application programming interfaces (APIs) – pose new technological challenges. However, the Patient-Specific Education measure is unchanged from Stage 2, and hospitals have already attested to thresholds well above the Stage 2 thresholds. Therefore, the threshold should remain at **35 percent**.

**Objective 6:** Measures to ensure that individuals can access and use their health information online, communicate electronically with their care team and share data relevant to their care have the potential to transform organizational practices and culture and drive high-quality, truly patient- and family-centered care. By drastically retreating on key patient and family engagement measures in 2018 – encouraging just one patient to view, download, transmit or access her health information through an app, and sending secure messages to just 5 percent of patients – CMS would greatly impede progress in delivery system transformation. CMS’s attestation data in October 2015 showed hospitals averaging 15.4 percent on the view/download/transmit measure for Stage 2. We urge CMS to preserve the existing thresholds for Stage 3:

- View, download, or transmit: **10%** of patients
- Secure messaging: **25%** of patients
- Patient-generated health data: **5%** of patients

**Objective 7:** We understand that technological challenges exist for meeting thresholds for incorporating summaries of care and reconciling clinical information in the Health Information Exchange objective. However, we urge CMS not to backtrack so drastically on thresholds in Objective 7. Not only sending but incorporating summaries of care and the Common Clinical Data Set are activities at the heart of improved care coordination and health outcomes, and CMS should prompt this needed progress through stronger requirements. We urge CMS to consider the following thresholds:

- Send electronic summary of care: **35%** of patients (reduce from 50%)
- Incorporate electronic summary of care: **25%** of patients (reduce from 40%)
- Clinical information reconciliation: **50%** of patients (reduce from 80%)

## **Patient-Facing Clinical Decision Support**

We generally support CMS’s intention to retire “topped out” measures that have achieved widespread adoption and occur at a high rate of performance. Thus, we agree with CMS’s proposal to retire the Computerized Provider Order Entry (CPOE) measure. However, we believe it is premature to retire the Clinical Decision Support (CDS) measure and urge CMS not to remove it.

Clinical decision support is not just a tool limited to doctors and hospitals. CDS exists in many forms and includes patient-facing and patient-engaging tools – tools that engage patients and families in care decisions through shared decision making, for instance – that are *not* as widely used as clinician-facing alerts. Only certain, largely clinician-facing uses of CDS approach widespread adoption and are “topped out,” such as drug-drug and drug-allergy interaction checks.

We urge CMS to maintain a clinical decision support measure to **encourage greater use of patient-facing CDS that engages patients and families in treatment decisions**. We offer two options for CMS’s consideration:

- **Alter existing measures:** Retire Measure 2 (drug-drug and drug-allergy intervention checks), but require hospitals to fulfill Measure 1, with a new focus on patient-facing CDS:
  - 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. At least two of these interventions must include uses of patient-facing CDS, such as tools for shared decision making. Absent four clinical quality measures related to an EH’s scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.”
- **Replace existing measures with new measure:** “Implement two CDS interventions that directly engage patients in the determination of care decisions, including tools for shared decision making.”

We also iterate the importance of maintaining existing CDS standards in certification requirements for health IT products (e.g. Infobutton standards) even if CMS does remove the CDS measure. Because the use of certified EHR technology is now required broadly across federal health care delivery and payment reform initiatives (e.g. the Merit-Based Incentive Payment System [MIPS] and Alternative Payment Models [APMs]), it is critical to preserve the CDS standards and infrastructure needed to support informed decision-making in collaboration with patients.

## Full-Year Reporting Period

CMS should retain full-year reporting in 2016. Providers and patients both need the ability to electronically exchange and use data *every* day, not staggered 90-day periods. A full-year reporting period also encourages providers to sustain changes to workflow and organizational procedures critical to more advanced uses of health IT that support interoperability and patient engagement. Consumers and providers alike recognize the benefits of a full-year reporting

period, as CMS noted in the proposed MACRA rule that providers often *prefer* a full-year reporting period.<sup>8</sup>

Thank you for this opportunity to comment on the proposed amendments to the Meaningful Use program. We look forward to working with CMS, ONC, providers, vendors and consumers across the nation to leverage technology to enhance the quality of care, foster trust with patients, bolster meaningful engagement and improve health outcomes. If you have any thoughts or questions about these comments, please contact Mark Savage at (202) 986-2600 or [msavage@nationalpartnership.org](mailto:msavage@nationalpartnership.org).

Sincerely,

AARP

American Association on Health and Disability

American Federation of State, County and Municipal Employees (AFSCME)

Asian & Pacific Islander American Health Forum

California Pan-Ethnic Health Network

Center for Democracy & Technology

Center for Independence of the Disabled, NY

Center for Medical Consumers

Consumers' Checkbook/Center for the Study of Services

Consumers Union

Family Caregiver Advocacy

Genetic Alliance

Healthwise

Hepatitis Foundation International

Informed Medical Decisions Foundation

NAACP

National LGBTQ Task Force

National Partnership for Women & Families

New Yorkers for Accessible Health Coverage

Pacific Business Group on Health

PXE International

The Children's Partnership

MaryAnne Sterling, Family Caregiver Advocate

Christine Bechtel, Consumer Advocate

---

<sup>8</sup> 81 Federal Register at p. 28180.