December 15, 2015

Submitted Electronically

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
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
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, DC 20201

>   Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3
>   and Modifications to Meaningful Use in 2015 Through 2017; Final Rule (CMS–3310 &
>   3311–FC)

Dear Administrator Slavitt:

The Consumer Partnership for eHealth (CPeH) and the undersigned 24 organizations and
individuals submit these formal comments on the finalized requirements for Stage 2
modifications and Stage 3 of the Meaningful Use program.[1] CPeH is a coalition of more than 50
consumer, patient and labor organizations working at the national, state and local levels to
advance private and secure health information technology (health IT) in ways that measurably
improve the lives of individuals and their families. The combined membership of CPeH
represents more than 127 million Americans.

Individuals cannot effectively manage their health and health care without accessible and
convenient information about their medications, health status, diagnoses and treatment received,
etc.[2] At the same time, providers cannot succeed under new models of care without activated and

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[1] The 24 organizations and members of the Consumer Partnership for eHealth and 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 rather than a single response.

[2] 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

engaged patients. We continue to believe that the Meaningful Use program is a unique national lever to advance patient online access to and use of their health data, which in turn has significant benefits for greater health system transformation. We were dismayed by the decision to finalize drastically diminished thresholds for patient use measures in Stage 2 in 2015-2017.

While we have concerns about the chilling effect the revised 'one patient' requirement will have on patient and provider education and outreach efforts, we appreciate CMS's decision to keep the Meaningful Use program moving forward, without further delay of Stage 3. Continuing the Meaningful Use program's trajectory as envisioned is critical to prepare for an effective transition into new models of payment and delivery in 2018 (e.g., under the Medicare Access and CHIP Reauthorization Act [MACRA]). Furthermore, proceeding with robust objectives and measures regarding electronic health information exchange is necessary to achieve the nation's goals as outlined in ONC's Interoperability Roadmap.

In our comments we respond briefly to finalized measures for Stages 2 and 3 and offer input on how to advance Meaningful Use, and electronic health information exchange more broadly, in the context of the new Merit-Based Incentive Payment System (MIPS) and forthcoming Alternative Payment Models (APMs).

I.   Comments on Stage 2 Modifications

We continue to be dismayed by the significant reduction of thresholds for two of the few measures of meaningful patient and family engagement in health care: dropping to just one patient's use of online access to health information, and merely turning on secure messaging in 2015 and just one patient's use in 2016**.** We are concerned that this retreat on use requirements will delay needed progress in interoperability, as well as in patients' participation and engagement in new delivery system reform efforts. Patients cannot possibly be active partners in care, effectively set or achieve health goals and treatment plans, or make informed decisions about high-value providers without accessible, electronic information about their health and health care.

The National Partnership's comprehensive national survey finds that patients who have utilized online access to their health information report that it has positively impacted their knowledge of

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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 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."

their health, ability to communicate with their doctor, and desire to do something about their health – activities that are essential to better care and improved health outcomes.[3]

We understand that providers will still be required to make health information available to fifty percent of patients electronically. We disagree, however, that the provision of online access alone is sufficient to honor previous commitments to patient engagement and will not thwart recent progress to engage patients and their family caregivers as true partners in their care. The actions required to notify patients of their ability to access, save a copy (download) and share (transmit) their health information electronically are minimal and passive – a poster on the wall, a postcard tucked in with the rest of the visit paperwork, a generic email from an unrecognizable sender. Without the parallel requirement that a small percentage of patients actually use the information available, there is no longer any imperative for providers to engage in a conversation with patients to help them understand the value and use of online access – when this is an effective strategy.

Furthermore, our recent national advocacy efforts have illuminated barriers individuals face in accessing and using their electronic health data. Consumers navigate a complex, time-consuming and costly process to request their digital health data with the traditional HIPAA records request process. In contrast, patient portals often provide the fastest, easiest and usually cost-free access to important clinical information. We are concerned about the effect the 'one patient' use requirement will have on portal outreach and education efforts at the point of care, as well as user-centered design initiatives at the vendor level. We are pleased to see that the five percent threshold will be reinstated in 2017, expanding beyond the 'one patient' requirement one year earlier than proposed. This progression will better prepare providers for the ten percent requirement finalized for Stage 3, which CMS must keep intact to effectively transition to new models of care in MACRA.

We remain disappointed in revisions to the secure messaging measure, which now merely requires providers to turn on the messaging function (for 2015) and send a single message to a single patient (for 2016). The change from counting *patient*-initiated messages to *provider*-initiated messages – whether messages to patients, in response to patient messages, or to other providers with patients copied – similarly allows providers to fulfill this measure without actively encouraging or engaging the patient in electronic communication. As we understand the measure, a blast email about the flu shot or summer camp form requests would meet the measure for 2017. The revised requirement, in allowing this kind of action, deviates from the original intent of the measure: providers' using secure messaging to enhance communication with individual patients, answer patient questions, or receive patient-reported outcomes and other critical information like

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[3] National Partnership for Women & Families. (2014, December). *Engaging Patients and Families: How Consumers Value and Use Health IT*, from http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf, pg. 29.

pain and functionality levels, etc. Moreover, this change to counting only provider-initiated messages removes the rationale for drastically reducing the measure threshold (turned on in 2015, one patient in 2016, five percent of patients in 2017) since patient action is no longer required.

We appreciate the inclusion of authorized representatives as individuals who can engage in activities to fulfill the patient engagement measures of Objectives 5 and 6. Family and other caregivers play an integral role in the coordination of care for their loved ones. Allowing family and authorized caregivers to access and use the health information of loved ones or send secure messages to providers reinforces and facilitates authorized representatives' role as vital members of the care team.

A better care experience means supporting patient and family participation as equal partners in their own health and health care decisions (as well as at the care design/redesign, governance, and community levels).[4] Drastically reducing thresholds for both patient and family engagement measures to one patient for at least the next two years instead stalls progress to change practice workflow and clinical culture to support substantive patient engagement through online access and health information sharing.

II.   Comments on Stage 3 Measures

In contrast, we are heartened to see CMS's commitment to the robust use of certified health IT and health information exchange exemplified in its requirements for Stage 3. By not allowing further delay, and moving forward on important new objectives and measures, CMS lays the necessary groundwork for delivery system reform efforts. Further disruption to the trajectory of the program would only delay improvements in interoperability, as many of the Stage 3 objectives stand to make significant progress on electronic exchange and use of health information, both among providers as well as with patients and families. Therefore, we commend CMS for finalizing the stated timeline and requirements for Stage 3 – specifically in Objectives 5, 6 and 7. Moving forward, however, we encourage CMS to retire the menu approach to Objectives 6 and 7 (only two of three measures need be satisfied) and require providers to satisfy all three measures of each objective, as appropriate, in MIPS and APMs.

Objective 5: Patient Electronic Access to Health Information

With respect to requirements to provide patients the ability to view, download and transmit (VDT) their health information electronically, we are pleased to see CMS finalize its alternate proposal to require providers to provide access to patients through both portals (VDT) and

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[4] Carman, K., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., & Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs*, 32(2): 223-23.

applications using application programming interfaces (APIs). This alternative ensures that patients continue to have access to functionalities often available through portals, including secure messaging and submission of patient-generated health data. Moreover, it allows us to understand the full implications of APIs before any exclusive use, particularly with respect to privacy and security concerns of applications storing data, as well as the impact on populations with limited Internet/smartphone use. At the same time, requiring APIs *in addition to* portals creates the potential for consumer-friendly innovations that support enhanced accessibility and use, consolidation of information, and greater information exchange.

Objective 6: Coordination of Care through Patient Engagement

We appreciate that CMS continues with the upward trajectory increasing the number of patients who use electronic access, by requiring a 10 percent threshold for 2018 in Stage 3. As we move into value-based payment programs in MACRA, patient use of online access, and the subsequent increase in patient engagement in their health and care, will become a cornerstone of efforts to coordinate care amongst all members of the care team and improve health outcomes.

Furthermore, we applaud CMS for finalizing the measure of personally-generated health data (PGHD), as the capture of PGHD and data from non-clinical settings helps to address a suite of issues needed for effective care coordination, holistic care, and person-centered health. Moreover, by incentivizing the sharing and incorporation of a wide variety of data from non-traditional sources, this measure has the potential to spur interoperability efforts that connect the clinical care setting with other health professionals and social services that influence patients' ability to get and stay healthy.

Objective 7: Health Information Exchange

We are heartened as well to see CMS finalize the measures and associated thresholds for the health information exchange objective, as they are fundamental to efforts to improve interoperability through enhanced data sharing and care coordination. Specifically, in finalizing the measure to require providers to *incorporate* summary of care records, CMS takes steps both to close the referral loop and coordinate care, and to increase interoperability among different eligible providers and EHR systems. We are particularly pleased to see that, in the sending and incorporation of summary of care records, these exchanges will include documentation of patient goals, care team members (including family caregivers), and unique device identifiers (UDIs)— all critical to ensuring safe, high-quality and coordinated care. As providers implement the reconciliation measure, we note that patients and their caregivers are valuable sources of information and should be included in the reconciliation process for specific information, especially information that is likely to change between encounters with the health care system.

III.   Incorporation of Meaningful Use into MACRA

The robust use of heath IT and health information exchange is critical in efforts to advance delivery system reform through MACRA, and is fundamental to achieving the goals of MIPS and APMs to incentivize high-quality, efficient practices, coordinated care, and improved health outcomes. As CMS considers how to incorporate the Meaningful Use program as an element of the MIPS, we are careful not to assume wholesale incorporation of current Meaningful Use requirements. We explain above our support for the finalized Stage 3 objectives and measures in part to underscore below why they should be incorporated into forthcoming requirements for MIPS and APMs. In particular, Objectives 5, 6 and 7 provide the necessary foundation for secure and robust information sharing and use between providers, as well as among patients, families and other designated caregivers (including social services and supports).

Thus, delay of Stage 3—as suggested by some stakeholders—would also undermine any effective transition to new models of care through MACRA, particularly in MIPS. **We call on CMS to keep the Meaningful Use program intact (both in terms of its structure and the content of its measures) as it is integrated into MIPS, and to incorporate strong patient and family engagement and care coordination measures of Meaningful Use into MIPS and APM requirements.** Furthermore, we encourage CMS to incentivize APMs to use advanced technical requirements of the 2015 Edition of Certified Health IT.

MIPS: Maintain the Structure of Meaningful Use

There are structural elements of the Meaningful Use program that must be retained or expanded in order to ensure that health IT is used in a significant manner to support value-based care. Firstly, CMS should retain full-year reporting for 2018 on. This allows for progress to continue in an uninterrupted manner—365 days per year, not just 90 days per year—on more advanced measures of health IT use, including summaries of care and patient online access.

CMS should also continue to require full attestation by eligible providers, meeting all measures and associated thresholds to be considered a meaningful user. The intent of MIPS (and MACRA as a whole) to incentivize high-quality, efficient practices would be undermined if providers were allowed to fail any Meaningful Use measure and associated threshold minimums and still receive (even) partial credit in the Meaningful Use category. Meaningful Use thresholds were carefully set such that *all* eligible providers had a chance to succeed. Accordingly, experience so far shows that, on average, providers are greatly exceeding thresholds.

Additionally, we are concerned that allowing providers to be selective about the measures on which they report would delay essential progress on more recent patient and family engagement measures (for example, the ability for patients to view, download and transmit to a third party their health information or to exchange secure messages with their provider). These patient-

facing measures often require providers to modify policies and workflows at the practice level, and also involve larger cultural shifts to view patients as active partners in care, not passive recipients – both of which take time, and both of which we cannot afford to delay further.

Finally, we are concerned that such a drastic change in measuring performance on Meaningful Use – allowing providers to pick which subset of core Meaningful Use measures they will actually implement and meet when all are essential for delivery system reform – could introduce new and unintended consequences. It is impossible to know what behaviors (favorable or not) such a design change will incentivize among providers.

We understand the reasons to provide flexibility for providers in this new performance model. However, the reasonable minimum thresholds, reporting flexibility, and exemptions currently employed in the Meaningful Use program already provide significant flexibility. Given the fundamental role that the meaningful use of certified EHR technology plays in promoting the ability to share and use data to enhance care delivery and improve health outcomes, CMS should continue to require providers to meet all measures and associated thresholds to receive full credit in the Meaningful Use performance category.

MIPS and APMs: Incorporate Patient and Family Engagement and Care Coordination Measures from Meaningful Use

As CMS considers how to incorporate Meaningful Use requirements into forthcoming MACRA payment models, at a minimum patient and family engagement and care coordination measures must be included. These measures serve as indicators of high achievement because they document uses of health IT that have great potential to facilitate patient and family engagement, promote care coordination and shared care planning, and ultimately improve health outcomes. For both MIPS and APMs, providers should be incentivized to fulfill three out of three measures for Objectives 6 and 7 (expanding upon the Stage 3 requirements where providers may meet two out of three measures). Providers should still be required to meet both measures of Objective 5.

For the sake of certainty and clarity, we summarize the requirements in Objectives 5, 6 and 7 of Stage 3 that MIPS and APMs should incorporate:

Objective 5: Patient Electronic Access to Health Information—Meet 2/2 Measures
- 80 percent of patients (or their authorized representatives) are provided access to their health information electronically through the view, download, transmit (VDT) function <u>and</u> through third-party applications utilizing application programming interfaces (APIs).
- 35 percent of patients are provided electronic access to clinically relevant patient-specific educational materials identified by the certified EHR technology.

Objective 6: Coordination of Care through Patient Engagement—Meet 3/3 Measures
- 10 percent of patients or their authorized caregivers use their ability to view online, download and transmit to a third party their health information.
- For 25 percent of patients, providers send a secure message to the patient or in response to a patient message.
- For five percent of patients, providers incorporate personally-generated health data or data from non-clinical settings into their EHRs.

Objective 7: Health Information Exchange—Meet 3/3 Measures
- For 50 percent of transitions of care or referrals, providers send electronic Summary of Care records electronically to physicians to whom they transfer or refer patients.
- For 40 percent of transitions of care or referrals, providers incorporate Summary of Care records into their EHRs from referring physicians.
- For more than 80 percent of transitions of care or referrals, providers perform clinical information reconciliation of medications, medication allergies, and problem list.

Such measures are especially relevant for APMs, as these providers should be leaders in fostering health information exchange both among providers and with patients and families. **As these measures of health IT use evolve and corresponding workflow and practice culture changes occur, we also encourage CMS to incorporate criteria that make advancements upon those in the Meaningful Use program.** For instance, APM participants should provide patients the ability to view, download and transmit their health data <u>within 24 hours</u> (accelerating the current timeline). The data available to patients should include data currently available in View, Download and Transmit requirements of the Meaningful Use program, as well as clinician notes.

<u>*APMs: Utilize Essential Functionalities in the 2015 Edition of Certified EHR Technology*</u>

Value-based care requires the use of **essential functionalities that are <u>already present</u> in the 2015 edition of certified EHR technology, <u>but are not yet included</u> in Meaningful Use requirements**. Therefore, we recommend that CMS leverage these important technology functionalities and develop parallel measures for APMs that encourage use of these functionalities. We include below some of the essential functionalities that would improve outcomes and value-based care.

Shared, electronic person-centered care plans
The 2015 Edition includes functionalities for both episodic plans of care and longitudinal plans. However, the health information exchange objective in Stage 3 of the Meaningful Use program only requires that providers include episodic plans of care for referrals and transitions of care. The longitudinal functionality synthesizes multiple plans of care for treatment across multiple settings and providers, serving as a blueprint or plan of action to guide and coordinate the patient's care over time – likely the kind of activity in which APM providers will routinely

engage. CMS should require APMs to use the certified longitudinal care plan functionality to better develop, maintain and exchange care plans, and track longitudinal improvement in outcomes. This will integrate:

- Electronic documentation of both patient <u>and</u> provider (clinical) goals;
- Electronic transmission of care plans to patients and caregivers across the care team; and
- Recording caregiver status and roles as appropriate.

These pieces of information engage patients and their caregivers in the planning of care, and provide the necessary foundation for a more person-focused, comprehensive, integrated care plan.

Materials in non-English languages
In order to provide electronic health information to *all* individuals in a format they can use, it must be available in non-English languages. Unfortunately, there has been limited progress on non-English language access. The 2015 Edition includes the optional capacity to request patient-specific educational materials in languages other than English, but Stage 3 does not require any provider to do so. Because more than 37 million Americans speak Spanish at home, we should be working now towards providing *all* health information at least initially in Spanish, and patient-specific educational resources at a minimum. However, since providers subject to the Meaningful Use requirements are also likely subject to Section 1557 of the Affordable Care Act, materials should also be made available in other languages, depending on the provider's service area and patient population.

Participants in value-based payment programs (particularly APMs) should provide patients electronic education materials specific to their needs in patients' preferred languages. Ultimately, APM participants should provide patients with access to all of their health information in Spanish at the very least, and preferably in the top 15 languages nationally, or by state or region.[5]

Meeting disability accommodation needs
While we were pleased by the final rule's inclusion of functional/disability status in Transitions of Care, participants in value-based payment programs must be incentivized to make meaningful use of this information. Once a disability or functional limitation is appropriately identified, providers in new payment and delivery models should take the next step of identifying, recording and

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[5] In its recent notice of proposed rulemaking regarding Section 1557 of the Affordable Care Act, the Department of Health and Human Services proposed using "the top 15 languages spoken by individuals with limited English proficiency nationally" in order to prevent discrimination based on language and national origin. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities NPRM," 80 Federal Register 54172, 54179 (Sept. 8, 2015). The NPRM also raised the question whether the top 15 languages should instead be assessed for each state or regionally rather than nationally. Id., p. 54180. Assessing by state or region captures additional languages important to ensure meaningful access for patients in a particular state or region.

acting upon accommodation needs for individuals with disabilities. Participants will fail to deliver timely, effective health care to people with disabilities, leading to increased costly urgent and emergency visits and institutionalization, if they cannot effectively or timely communicate with patients, or provide needed physical and programmatic accommodations.

Linking to community resources and social services
We applaud that Stage 3's regulations include not only capture of patient-generated health data (PGHD), but also capture of relevant health data from non-clinical settings. Similarly, the 2015 Edition includes a health IT criterion to capture relevant social, psychological and behavioral data. We envision that providers' use of health IT to link patients to such community resources would build upon these advancements in Stage 3's PGHD measure and the 2015 Edition to incorporate data from non-clinical settings. Activities that integrate social determinants of individuals' health and promote social and community involvement by linking the EHR to community and social services will be a critical part of efforts to improve shared health and care planning.

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Thank you once again for the opportunity to provide input into the transformative programs of Meaningful Use and new payment and delivery models under MACRA. Robust advancement of Stage 3 Meaningful Use criteria that focus on improvement of outcomes in these new models is critical to ensure that delivery system reform efforts result in better care, smarter spending, and healthier people. We look forward to working with CMS, ONC, providers, 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.

Sincerely,

Alliance for a Just Society
American Association on Health and Disability
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Boston Public Health Commission
California Pan-Ethnic Health Network
Caring from a Distance
Center for Democracy & Technology
Center for Elder Care and Advanced Illness, Altarum Institute
Consumers' Checkbook/Center for the Study of Services
Consumer-Purchaser Alliance
Disability Policy Consortium
(*continued below*)

Disability Rights Education and Defense Fund
Family Caregiver Advocacy
Healthwise
Informed Medical Decisions Foundation
Lesbian Health Initiative
National Consumers League
National Health Law Program
National Latina Institute for Reproductive Health
National Partnership for Women & Families
The Children's Partnership
Universal Health Care Action Network of Ohio

Mary Anne Sterling, Family Caregiver Advocate