

## **Collaborative Comments on the Centers for Medicare and Medicaid Services' Notice of Proposed Rulemaking for the Electronic Health Record Incentive Program (CMS-0033-P)**

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*These comments were jointly developed with a broad array of collaborators, including the Markle Connecting for Health community, the Center for American Progress, and the Engelberg Center for Health Care Reform at Brookings.*

1 The release of the Notice of Proposed Rulemaking (NPRM) for the Centers for Medicare  
2 and Medicaid Services' (CMS) incentive program for the Meaningful Use<sup>1</sup> of electronic  
3 health records (EHRs) marks a major, positive step forward in the nation's efforts to  
4 improve health and health care by putting modern information technology (IT) tools at  
5 the fingertips of medical professionals and consumers alike.

6 We applaud the US Department of Health and Human Services (HHS) for establishing  
7 an important set of priorities and drafting targets that are, in general, both ambitious  
8 and staged to enable broad participation. This was a very challenging and novel  
9 undertaking, and the result is an important contribution to the potential of information  
10 technology to improve the quality and efficiency of health care. In particular, the NPRM:

- 11 • states that the goal of health IT is to improve health quality and efficiency
- 12 • embraces patient engagement as a key aspect of Meaningful Use
- 13 • establishes metrics for health improvement rather than focusing merely on  
14 acquiring technology
- 15 • adopts a phased approach to allow for technology development and testing at  
16 initial stages
- 17 • largely proposes simple and easy-to-use requirements for reporting quality  
18 results
- 19 • makes progress aligning various HHS quality reporting initiatives and  
20 eliminating the need for duplicative reporting

21 While the NPRM takes substantial strides in the right direction, our comments offer  
22 specific suggestions for clarifying the regulations and ironing out workable  
23 implementation details to achieve the urgent priorities of this effort: improving health

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<sup>1</sup> Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed rule. 75 Federal Register 8 (January 13, 2010), pp. 1844–2011.

24 and efficient use of health care resources, protecting privacy, and encouraging  
25 innovation and broad participation across many health care settings.

26 In this set of collaborative comments, advanced by a diverse array of health leaders, we  
27 offer our comments and recommendations on the NPRM in five distinct categories:

- 28 I. goals and quality measures
- 29 II. eligibility and reporting
- 30 III. patient engagement
- 31 IV. feedback and payment
- 32 V. clarification and technical fixes

### 33 **I. Goals and Quality Measures**

34 **Recommendation 1**                      **Align and prioritize HITECH investments by**  
35 **making health goals and targets more explicit.**

36 **ISSUE:** The health goals prioritized by Meaningful Use requirements are not explicit.  
37 The objective of Meaningful Use, clearly stated in the NPRM, is to improve health care  
38 quality, efficiency, and patient safety, and not adoption of health IT as an end state.  
39 There are many quality metrics in the NPRM, but they have not been specified as a set of  
40 clear and measurable health goals the investments must achieve. In the absence of clear  
41 goals that are well understood by the provider community and the public, efforts to  
42 comply with Meaningful Use will risk becoming an exercise in satisfying process and  
43 reporting requirements rather than an opportunity to improve health and efficiency  
44 *using* both health IT and changes in care delivery.

45 **RECOMMENDATION:** Clarify and make explicit the health goals and targets for HITECH  
46 investments, centered on national priorities and the health objectives already implicit in  
47 the Meaningful Use quality measures. These goals are already implied by the clinical  
48 measures proposed in the rule; making them explicit allows CMS to set national targets  
49 for their attainment.

50 Goals that can already be extrapolated from the current Meaningful Use quality  
51 measures include:

- 52 • Reduce hospital readmissions.
- 53 • Improve medication management (safe medication use and effective medication  
54 management for heart disease, diabetes, asthma, mental health conditions, and  
55 hospital procedures).

- 56 • Improve care coordination and reduce gaps in care.
- 57 • Improve chronic care management, including blood pressure, diabetes, and
- 58 cholesterol control.
- 59 • Improve preventive care, including healthy weight and smoking cessation.
- 60 • Improve patient safety.
- 61 • Reduce disparities.
- 62 • Increase efficiency and appropriate use of resources.
- 63 • Improve active engagement of patients in their care.

64 **RATIONALE:** The Meaningful Use regulations are an opportunity for HHS to establish a  
 65 set of goals that would (1) provide meaning and context for those participating in the  
 66 EHR incentive program, and (2) align and prioritize the broader set of HITECH  
 67 investments.

- 68 • **Clear health goals will bring meaning and context to the staging of**  
 69 **Meaningful Use.** The phases outlined in the NPRM recognize a learning curve  
 70 for clinicians and provider organizations using health IT systems to improve  
 71 health. But if the phases are unhinged from the ultimate objectives—“In Stage 1, I  
 72 document structured data; in Stage 2, I implement decision support, and finally  
 73 in Stage 3, let me see what impact I am having”—adopters will be less likely to  
 74 achieve the anticipated impact. Each activity—from documenting structured data  
 75 to implementing decision support—must be carefully and iteratively  
 76 implemented with the health goals clearly in mind so that necessary process and  
 77 care delivery changes are considered at each step. Explicit overarching goals are  
 78 critical to achieving the Meaningful Use objectives and will encourage innovation  
 79 in both care delivery and technology. Relying only on a set of quality measures or  
 80 a step-by-step, process-driven approach will not substitute.

- 81 • **Health goals are necessary to align and prioritize the many areas of**  
 82 **HITECH investment and the array of federal activities.** Clear and explicit  
 83 health objectives are needed to identify and prioritize health IT requirements,  
 84 related standards and certification criteria and to determine whether investments  
 85 in health IT are leading to improvements in health. Clear objectives are also  
 86 necessary to encourage alignment between Meaningful Use and the Beacon  
 87 Grants, as well as health information exchange and state efforts, which will be  
 88 important for supporting eligible professionals (EPs) and hospitals in achieving  
 89 Meaningful Use. This level of coordination and alignment cannot be achieved  
 90 solely through enumerating quality measures.

91 **Recommendation 2** **Prioritize quality measures.**

92 **ISSUE:** The list of quality measures must be focused. The NPRM makes substantial  
93 strides in assigning relevant measures to hospitals and physician specialty groups  
94 reflecting both overarching health goals like improving preventive care and medication  
95 management, and more specific objectives relevant to each specialty. However, the  
96 current list of measures is long and risks being disconnected in purpose and process,  
97 rather than outcome-driven. This can have significant consequences for provider  
98 participation. We recommend an approach that is driven by outcomes, prioritized  
99 around explicit health goals, only uses “measures that matter” and thereby simplifies  
100 workload for providers. Measures of clinical quality, in particular intermediate and  
101 outcome measures, provide the most direct way of measuring whether health care goals  
102 have been met.

103 **RECOMMENDATION:** Prioritize quality measures for specialties for which more than five  
104 measures have been recommended. The NPRM’s proposal of identifying a small number  
105 of shared measures and three to five quality measures specific to each eligible  
106 professional (EP) specialty is a good one. The current lists of measures for primary care  
107 and some other specialties need to be considerably focused around specific health goals.  
108 A focused and narrowed list of quality measure is also needed for hospitals.

109 We recommend narrowing the lists of quality measures based on the five criteria below:

- 110 1. Favor intermediate and outcome measures.
- 111 2. Address multiple priority health goals.
- 112 3. Be “exemplar” measures that will necessitate and demonstrate the use of critical  
113 health IT functions.
- 114 4. Be “well established” and in wide use whenever possible.
- 115 5. Eliminate redundancy (e.g., remove identical measures with different thresholds,  
116 eliminate a process measure if the related intermediate outcome measure is  
117 available, eliminate specialty specific measures already addressed by core  
118 measures).

119 Please see [Appendix A, Recommendation 2](#) for one possible approach to prioritizing the  
120 quality measures using the criteria.

121 **RATIONALE:** A prioritized list of outcome-oriented measures will deliver more useful  
122 information to CMS and concentrate and focus the quality improvement activities—  
123 including effective use of health IT—of hospitals and EPs. This approach has the  
124 potential to make the measures more meaningful to physicians, allow for needed  
125 flexibility and thereby increase the number of providers likely to participate.

126 **Recommendation 3** **Identify new quality measures to fill gaps.**

127 **ISSUE:** There are gaps in measures in several key areas. The current list of quality  
128 measures is lacking compelling outcome metrics for several priority areas, including  
129 patient engagement, efficiency and overuse, and care coordination.

130 **RECOMMENDATION:** Rapidly develop new quality measures for Stage 2, addressing  
131 priority health goals such as overuse and efficiency, care coordination, patient safety,  
132 and patient engagement for which strong outcome-oriented measures are lacking.  
133 Preference should be given to the development of intermediate and outcome measures,  
134 and viable risk-adjustment approaches. In addition, measures that reflect patient  
135 progress and outcomes across the care continuum and settings are critical and should be  
136 developed. These measures give providers and hospitals critical information about  
137 patient progress across groups of clinicians that may care for them.

138 **RATIONALE:** Immediate efforts are needed in rapid and effective measure development  
139 to ensure that outcome-oriented measures can be deployed in the near future. The goal  
140 is not rapid expansion of the number of measures, but judicious focus on outcome  
141 measures that can show clear improvement towards priority health goals. Too many  
142 measures will not necessarily yield better quality and can result in measure fatigue, lack  
143 of participation, and loss of focus.

144

145 **II. Eligibility and Reporting**

146 **Recommendation 4** **Re-evaluate the all-or-none payment**  
147 **approach.**

148 **ISSUE:** The NPRM requires EPs and hospitals to fulfill all requirements in order to  
149 receive Meaningful Use incentives. This approach to payment will be too rigid in that it  
150 gives CMS little room to iteratively implement such a large and complex program (i.e.,  
151 making necessary refinements based on feedback and early experience). It also risks  
152 discouraging participation by providers who can meet the vast majority of the  
153 requirements, but not every one. This problem may be particularly salient for providers  
154 in small-practice settings. What will happen if a physician misses by one measure? What  
155 if a measure proves impossible to achieve, or needs to be redefined? Rigorous  
156 requirements need to be matched with a degree of flexibility and ample room to reflect  
157 early implementation experience in ongoing program improvements.

158 **RECOMMENDATION:** CMS should allow EPs and hospitals to qualify for incentive  
159 payments for achieving a high proportion of, but not all, measures in the first year.

160 Please see [Appendix A, Recommendation 4](#) for one potential specific strategy to allow  
161 flexibility in how EPs and hospitals will achieve Meaningful Use while maintaining  
162 rigorous requirements.

163 **RATIONALE:** The NPRM outlines ambitious aims for Meaningful Use, including the  
164 requirement of meeting more than 20 specific measures. It is difficult to predict which  
165 measures will be most challenging to achieve. The all-or-none payment approach risks  
166 discouraging overall participation, especially among providers in small-practice settings  
167 and those with limited IT support or experience. Keeping rigorous requirements while  
168 introducing a degree of flexibility will improve participation levels because it will leave  
169 room for some provider discretion based on practice type and inevitable variations in  
170 adoption levels and IT capabilities.

171 **Recommendation 5**                      **Simplify and streamline the functional**  
172 **measures.**

173 **ISSUE:** Significant reporting burden is created by requiring numerator/denominator  
174 results for a large array of functional measures, some of which are only currently  
175 calculable through manual tracking. Our prior collaborative comments underscored that  
176 measures to demonstrate Meaningful Use should be outcome-oriented, reportable as an  
177 automatic output of qualified health IT and chosen to avoid creating unneeded  
178 administrative burdens for physicians and hospitals or making reporting into a  
179 compliance, rather than a true quality improvement, effort.

180 The NPRM lists a series of “functional” measures, calling on EPs and hospitals to  
181 demonstrate use of particular health IT capabilities such as recording patient vitals and  
182 demographics, sending preventive care reminders and using e-prescribing. These  
183 functions are critical foundational elements, and are necessary prerequisites for  
184 demonstrating Meaningful Use of health IT to improve quality, efficiency, and patient  
185 safety. But the NPRM places too much emphasis on calculating and reporting a specific  
186 performance level for each one of these capabilities, potentially creating unnecessary  
187 reporting burdens for physicians without clear evidence that they will result in quality  
188 improvements. A particular concern is the measures that require cumbersome manual  
189 tallying of paper-based processes to calculate the denominator.

190 Many of the functional capabilities are required to calculate quality results (e.g.,  
191 demographics, vitals, problems). In early stages it is important to reinforce accurately  
192 capturing this core information. Over time, compelling clinical measures that depend on  
193 this core information should replace functional measures whenever possible.

194 **RECOMMENDATION:** Simplify the functional measures to reduce burden and de-  
195 emphasize process reporting.



228 • is easily implemented across a broad range of providers and technology settings.  
229 There should be simple and easy-to-use requirements for electronically reporting  
230 summary results

231 • provides timely acknowledgement to providers and allows for testing of  
232 submission capabilities before they are implemented

233  
234 **RECOMMENDATION:** Establish electronic reporting mechanisms that are easy-to-  
235 implement in the near term and rely on approaches that are already in demonstrated  
236 use across an array of providers.

237 • Clarify that providers will submit summary statistics for each quality measure to  
238 CMS, defined as simple numerators/denominators reflecting the experience of  
239 the provider’s entire patient population (e.g., 5/7 of Dr. Smith’s patients with  
240 hypertension have controlled blood pressure).

241 • Adapt and use the PQRI registry XML for electronic reporting of  
242 numerator/denominator for quality measures in Stage 1. To date there has been  
243 too little experience with QRDA level III—which supports reporting of summary  
244 results—to determine if this standard will be an easy-to-use and implement  
245 mechanism for quality reporting from a variety of electronic systems in Stage 1.

246 • We recommend that CMS simplify both the reporting and feedback interaction  
247 between providers and CMS, even for Stage 1, offering a mechanism where a  
248 report from a provider can be uploaded and immediately tested for accuracy of  
249 format and consistency of content, similar to e-filing results from the IRS (see  
250 Recommendation 9 Provide Timely Feedback to Physicians). In future stages, it  
251 may be advantageous to implement ongoing monitoring of quality from provider  
252 care processes, something that can be performed by a variety of entities including  
253 third parties, health information exchanges, research entities, and vendors,  
254 among others.

255 • It should be possible for groups of physicians working together to improve care  
256 quality and safety to report collectively rather than as single providers.

257 • The model for reporting described in the NPRM in which detailed health  
258 information is retained locally in individual EP or eligible hospital EHRs, and  
259 only summary reports are submitted to CMS is neither an “alternative” nor a  
260 “network of distributed EHRs” and this reference can be confusing. This model is  
261 the required and most viable way of accomplishing the quality reporting  
262 objectives of Meaningful Use while limiting disclosure of identifiable information.  
263 There is a need in other population health areas to address distributed methods



264 for research, public health, and other quality measurement activities where it is  
265 necessary to look at composite information across the network.

266  
267 **RATIONALE:** The NPRM indicates that EPs and hospitals will use the PQRI registry  
268 XML for quality reporting in 2012, and requests comment on whether the QRDA CDA  
269 standard should be adopted for quality reporting in future years.

270 The PQRI registry XML is a good template; it is in wide use, is easy to implement, and  
271 CMS is already accepting numerator/denominator results using this mechanism. The  
272 template can be rapidly updated and scaled to support direct submission from electronic  
273 systems. The Office of the National Coordinator's popHealth prototype software for  
274 reporting summary quality measures or data to public health is a very positive step in  
275 leveraging established standards and Web-based tools for quality reporting across an  
276 array of providers.

277 By contrast, experience with the QRDA standard is much more limited. A patient-level  
278 version of the standard has been used in CMS's PQRI EHR demo, and an alternative  
279 version of the standard supports population health reporting, but has not been broadly  
280 implemented. In addition, it is not clear that the detail and complexity of the standard is  
281 necessary to support the numerator/denominator reporting for quality measures  
282 required in Stage 1 by the NPRM.

283 Finally, for quality improvement, qualified health IT must have the capacity to generate  
284 summary measures for providers on demand and give them the capacity to readily  
285 produce the detailed underlying data for their own quality efforts and to support  
286 improvements in care delivery.

## 287 **Recommendation 7 Refine and test e-measure specifications.**

288 **ISSUE:** The NPRM does not describe how testing of quality measure specifications and  
289 reporting will be conducted. The NPRM indicates that detailed specifications for e-  
290 measures will be released in April 2010, but little information is provided about how  
291 these e-measures will be developed or tested.

292 **RECOMMENDATION:** Initiate a process and timeline for providers to test quality  
293 measure specifications and submission capabilities before they are put into use for  
294 electronic reporting in 2012. The definitions should be reviewed and tested to be sure  
295 they satisfy the following requirements before they are finalized and deployed for  
296 electronic reporting in 2012, and systems should be tested for whether they can  
297 successfully submit them:

- 298 • **Electronic measure specifications must be clear, as simple as**  
299 **possible, and consistent with standards recommendations in the IFR.**

300 It will be necessary to outline the “logic” of how electronic systems need to  
301 calculate the measures, without overspecifying the exact processes and  
302 mechanisms electronic systems will use for measure calculation.

303 • **Testing will be required to demonstrate that qualified health IT**  
304 **systems can implement and use the specifications to accurately**  
305 **calculate measures.** This will require testing across a variety of systems to  
306 identify issues before specifications are finalized as well as testing calculation of  
307 measures in each system as part of certification.

308 • **Testing will be required to assure that providers can accurately**  
309 **calculate measures and report them to CMS.** This will require  
310 mechanisms for providers to test measure calculation in their systems, validate  
311 source data, and test roundtrip submissions to CMS (i.e., sending data and  
312 receiving confirmation). Providers must also have the ability to monitor and  
313 assess their own progress on demand using their electronic systems.

314 **RATIONALE:** Testing of e-measures across a variety of provider settings and technology  
315 platforms will provide an early warning of any issues that need to be resolved and an  
316 opportunity to iteratively refine and improve the specifications before they are finalized  
317 and deployed. This process will increase EP and hospital confidence and reduce the risk  
318 of frustration during initial stages of quality reporting.

### 319 **III. Patient Engagement**

320 **Recommendation 8**                      **Allow low-burden means to achieve Stage 1**  
321 **patient engagement.**

322 **ISSUE:** The patient engagement requirements in the NPRM affirm the core expectation  
323 that the individual should have ready access to copies of personal health information in  
324 a useful electronic format. The ability for an individual to obtain certain personal health  
325 information in electronic format is now firmly rooted in federal law. And given the  
326 public investment in health IT in the Recovery Act, it is a core requirement for  
327 Meaningful Use.

328 The NPRM appropriately prioritizes critical information such as after-visit and  
329 discharge instructions, lab results, and lists of problems, medications, and allergies to be  
330 made electronically accessible to individuals. We strongly support this as a priority  
331 Stage 1 Meaningful Use requirement.

332 None of the health goals implicit in the NPRM—improving care coordination,  
333 controlling chronic diseases, addressing disparities, reducing smoking, improving

334 medication safety, or using health care resources efficiently—can be achieved without  
335 the participation and support of patients and consumers. Requiring qualified health IT  
336 to enable providers to provide individuals with printed care summaries or the option to  
337 download electronic copies of their personal health information will not, by itself,  
338 cement patient activation toward these important national aims, but it is a necessary  
339 start.

340 We encourage HHS to steer future stages of Meaningful Use toward a broader vision of  
341 patient engagement with the aid of health IT.

342 The vision should:

- 343 • Consider individuals as information participants—not as mere recipients, but as  
344 information contributors, knowledge creators, and shared decision makers and  
345 care planners.
- 346 • Shift paradigms so that information is not provided to individuals only upon  
347 request, but is delivered routinely after every visit in a format that matches the  
348 individual’s needs and wishes.
- 349 • Encourage the extension of communication and feedback cycles among  
350 individuals and care teams beyond episodic, office-based encounters.
- 351 • Enable individuals to compile copies of their information on a timely basis and  
352 share it through a wide variety of applications and services of their choosing.
- 353 • Research and develop new patient engagement performance measures that are  
354 directly tied to health improvement goals.

355 In general, the Stage 1 patient engagement priorities in the NPRM provide basic  
356 building blocks for this vision. However, given the aggressive timelines and the  
357 imperative for broad participation by providers and hospitals, the specific requirements  
358 could be more powerful if they were simplified and permissive of low-burden means of  
359 attainment.

360 We recommend below that CMS consolidate and simplify the different requirements for  
361 “timely electronic access,” “electronic copies,” and summaries or instructions to be  
362 delivered to patients after doctor or hospital visits.

363

364 **RECOMMENDATIONS:**

365 **(1) HHS should modify the NPRM and the IFR to clarify that a secure**  
366 **download capability is an allowable option** to provide “electronic copies” of

367 information, “timely electronic access” to records, and clinical summaries (for eligible  
368 professional) and discharge instructions (for hospitals).

369 This download function should:

- 370 • Be accessible to the patients of an eligible professional or a hospital from a secure  
371 online site. Examples of such sites include patient portals or personal health  
372 records, but also could be nothing more than a secure way for patients to log in  
373 and download copies of their information.
- 374 • Be a required capability of qualified health IT. The technical requirements should  
375 include automation of counts of basic utilization (e.g., number of clinical  
376 summaries and hospital discharge instructions delivered, number of patients who  
377 log in, number of electronic downloads requested and delivered.)
- 378 • Make available appropriate priority information, enumerated in the patient  
379 engagement sections of the NPRM and IFR, for example:
  - 380 ▪ lists of problems, medications, allergies, immunizations, and procedures
  - 381 ▪ laboratory and diagnostic test results
- 382 • Be offered in lieu of paper or in addition to paper, based on individual patient  
383 choice.
- 384 • Be offered as a preferred alternative to compact disc or USB drive (except for  
385 images) because of security and interoperability concerns related to portable  
386 storage devices.
- 387 • Encourage standardized clinical summary formats listed in the IFR (e.g., CCD or  
388 CCR), and require human readability and commonly used software file formats  
389 (e.g., text, spreadsheet, PDF) in Stage 1 to accommodate patient preference.

390 By recommending that this capability be made an allowable option to satisfy the Stage 1  
391 patient engagement requirements, we do not suggest that it be the only such option. If  
392 an EHR is being used to meet the requirements in the NPRM, (e.g., has a functioning  
393 patient portal that displays the information but no download option), that should not  
394 prevent the provider from using it to achieve Stage 1 Meaningful Use in the patient  
395 engagement category.

396 However, we do recommend that the download capability be added to the criteria for  
397 qualified health IT. Thus, it should be an *allowable option for providers* in Stage 1, and  
398 be *required* as a criterion for deeming health IT qualified.

399 **(2) CMS should set a general expectation around the timeframe that**  
400 **providers should share electronically with patients the priority information**  
401 **types listed in the patient engagement sections of the NPRM and IFR.**

402 We acknowledge CMS' challenge in finding an appropriate compromise for the  
403 maximum lag time between when the information is available to the provider and when  
404 it must be available electronically to the patient. From the perspective of patients and  
405 their advocates in the Internet age, there should be little or no lag time. Rapid delivery  
406 of information can help avoid complications and save lives. On the other hand, many  
407 providers have workflow issues that make immediate turnaround times difficult to  
408 routinely achieve in Stage 1. In addition, many providers feel they have a professional  
409 obligation to avoid releasing certain types of information, such as new diagnoses,  
410 immediately to patients because the provision of raw information without interpretation  
411 and counseling from a clinician may be harmful to some patients. There is legitimacy to  
412 each view. The general goal, however, should be for the federal investments in health IT  
413 to speed up the delivery of useful information to patients.

414 As written, the NPRM does not clearly delineate when information falls under  
415 "electronic copies" (with a 48-hour requirement for turnaround to patients) or "timely  
416 electronic access" (with a 96-hour turnaround). CMS should set a general expectation  
417 and avoid confusion that would result from having several different requirements for  
418 different types information. We recommend setting expectations around two types of  
419 information listed in the patient engagement sections of the NPRM and IFR:

- 420 • **Information that should be shared at the end of each clinical**  
421 **encounter:** After-visit clinical summaries and hospital discharge instructions  
422 should be offered at the end of each clinical encounter or discharge.
  
- 423 • **Information that should be shared within two business days:** All other  
424 Stage 1 patient engagement information example types in the NPRM (problems,  
425 medications, allergies, lab results, etc.) should be available for electronic  
426 download to an EP's or hospital's patients no later than two business days after  
427 the information is available to the EP or hospital. If a download capability were a  
428 function of qualified health IT, we believe that two business days from when the  
429 information is available to providers is a reasonable expectation for the  
430 maximum lag time before it should become available for electronic download by  
431 patients.

432 **(3) Simple attestation will be the most practical means for providers and**  
433 **hospitals to report attainment of the patient engagement requirements in**  
434 **Stage 1.** Because of the novelty of this approach and the complexities of defining a  
435 denominator that could be used to calculate thresholds, the patient engagement  
436 requirements should not require specific thresholds in Stage 1. They should require only

437 a few basic counts tallied by the qualified IT system (e.g., numbers of clinical summaries  
438 and discharge instructions delivered, number of patients who initiate secure access  
439 accounts, number of electronic downloads delivered).

440 **(4) To signal the future direction in later stages, CMS should set clear**  
441 **threshold percentages for patient engagement** (e.g., clinical summaries delivered  
442 in X percent of visits, Y percent of patients registering on a secure Web site where  
443 downloads of electronic copies are available). However, the reporting requirements to  
444 demonstrate achievement of those thresholds should be phased in after the first  
445 reporting year. CMS should also make clear that those future thresholds will take into  
446 account an EP's or hospital's patient engagement activities during the Stage 1 period. In  
447 summary, providers and hospitals should be motivated to engage as many patients as  
448 possible during the Stage 1 years, but it is too early to require them to report their  
449 numerators and denominators to satisfy the patient engagement components of  
450 Meaningful Use during that time.

451 **5) Historic records that have not been converted to electronic format, or**  
452 **entire medical files beyond the Stage 1 patient-engagement information**  
453 **types, should not be subject to the expectation for online access in Stage 1 of**  
454 **Meaningful Use.** Of course, patients will remain entitled to request and receive their  
455 full medical records under HIPAA.

456  
457 **RATIONALE:**

458 • **A download capability is a big step forward for most people.** A  
459 standard, secure access, download function would allow patients to leave a  
460 doctor's office or hospital with the option to log in afterward to retrieve pertinent  
461 copies of information. Most Americans do not have such an option today. Not all  
462 people will be able or willing to download copies of their information online, and  
463 nothing in the regulation should discourage people from requesting and receiving  
464 paper copies of their information if that is the format they request. However,  
465 those who are willing and able to receive their information through an online  
466 download button can drive improvements in service and timeliness that  
467 eventually benefit everyone.

468 • **A download capability is a low-burden means for providers and**  
469 **hospitals to improve service and coordination of care.** Rather than  
470 spending time measuring how many patients request information electronically  
471 and the percentage of those requests that are fulfilled, it would be more  
472 meaningful if providers simply had built into their system the capability for  
473 patients to download copies of their information, and for that capability to be  
474 offered routinely to all patients. The capability should have embedded means for

475 tracking delivery of information to patients and should be minimally disruptive  
476 to clinical workflow and back office burdens.

477 • **A download capability is a low-burden means for health care entities**  
478 **to comply with laws and regulations.** As the NPRM notes, Section 13405 (e)  
479 of HITECH establishes an individual’s ability to request certain information in  
480 electronic format from EHRs and have it sent to a service of the individual’s  
481 choosing. Including the option for patients to download information online in the  
482 Meaningful Use regulation would help participating providers meet legal  
483 requirements for individual access to information in electronic format.

484 • **A download capability reduces the burden of many user interface**  
485 **decisions.** If Stage 1 patient engagement requirements can be met with a  
486 download button, providers and vendors need not invest a great deal of time  
487 early in the adoption cycle concerned about how each page of a patient portal will  
488 look like or function for their patients. Supporting and implementing a patient  
489 portal may not be a practical endeavor for many providers, particularly those in  
490 small-practice settings. Not every vendor and provider is suited to or capable of  
491 supporting patient portals, developing high value applications for patients to use,  
492 and dealing with implementation and adoption challenges. In fact, it is not  
493 desirable to see every holder of a patient’s data also as the purveyor of patient-  
494 facing portals or applications. This may be untenable for patients and providers  
495 alike. Rather, we recommend that HHS support the individual’s ability to use  
496 services to compile and make use of copies of health information from multiple  
497 providers and sources. We describe the vision, architecture, and recommended  
498 practices for such services (which we call Consumer Access Services) in the  
499 Markle Connecting for Health Common Framework for Networked Personal  
500 Health Information.<sup>2</sup>

501 • **A download capability is relatively easy to add to EHR systems.** Patient  
502 portals are increasingly bundled with EHR systems. It should not be difficult for  
503 most vendors or technology departments to add a download option to a patient  
504 portal or secure access site, particularly if Stage 1 of Meaningful Use identifies  
505 this option for satisfying patient engagement requirements. It should also be  
506 made easier because other vital components of the NPRM already require EHR  
507 systems to be able to extract data sets to support care transitions.

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<sup>2</sup> *Markle Common Framework for Networked Personal Health Information, Overview and Principles*, Markle Foundation, June 2008. Available online at the following URL: <http://www.connectingforhealth.org/phti/reports/overview.html>.

- 508 • **A download capability provides an easier path to interoperability.** The  
509 download feature clearly separates data from applications (i.e., the patient can  
510 access and keep copies of the information without being locked into a particular  
511 portal or application). This critical separation makes it technically easier for  
512 various services of the patient’s choosing to parse and use the downloaded  
513 information. In general, the IFR implicitly supports the basic idea of a download  
514 *capability*, but we recommend that both the NPRM and the IFR explicitly  
515 identify that option for Stage 1 compliance for providers and make it a criterion  
516 for qualified health IT.
- 517 • **A download capability is likely to build market pressure for**  
518 **standardization.** Ultimately, structured data is a dramatic accelerator for the  
519 development of applications that may use the information for the consumer’s  
520 benefit. The consumer finance and online banking sectors demonstrate that  
521 making personal information directly accessible to consumers increases demands  
522 for standards to improve industry efficiency.
- 523 • **A download capability is likely to build patient demand for**  
524 **aggregative and value-added services.** The consumer finance and banking  
525 sectors also demonstrate that when individuals get to download their personal  
526 information into applications, they demand services that help pull together  
527 information from various accounts and institutions. A first step is simply making  
528 the information available. This, in turn, increases expectations and demand.  
529 Innovation will follow.
- 530 • **A download capability clarifies patient responsibilities.** In the digital  
531 age, all electronically obtained information is essentially a copy. Whenever  
532 patients download a copy of information from a provider’s Web site, they must be  
533 advised that they are responsible for the management of that information.  
534 Providers, of course, remain responsible for managing the copies of the  
535 information in their own EHR systems. But they are not responsible for any  
536 decisions that the individual makes with respect to the copy that the individual  
537 downloads and possesses.

## 538 **IV. Feedback and Payment**

### 539 **Recommendation 9 Provide timely feedback to physicians.**

540 **ISSUE:** The process for demonstrating Meaningful Use must foster provider confidence.  
541 Other than stating that payment will be made on a rolling basis, the NPRM does not



542 address the mechanisms, timing, or content for CMS to acknowledge or provide  
543 feedback on Meaningful Use results providers send. It is important for providers to get  
544 information back from CMS on whether the transmission was successful, whether there  
545 were any problems with the information, whether Meaningful Use was achieved, and,  
546 over time, information about trends and peer benchmarks.

547  
548 **RECOMMENDATION:** Establish specific timelines and processes for CMS to provide  
549 timely and relevant acknowledgment, payment and feedback to EPs and hospitals, and  
550 time and resources for adequate testing of all submission mechanisms and reporting  
551 processes.

552 CMS should specify timelines, processes, and testing mechanisms for:

- 553 • accepting and confirming successful receipt of information, including date CMS  
554 received the file, that the TaxID/NPI exists for the provider, summary statistics of  
555 the content and confirmation of acceptable format and numbers
- 556 • identifying and addressing any problems in submission
- 557 • promptly paying providers based on achievement of Meaningful Use
- 558 • providing trend and benchmark information (Stage 2)

559 These steps would not need to occur all at once, but can be sequenced.

560  
561 **RATIONALE:** Providing timely and useful feedback to participants as well as interfaces  
562 to test information submission will help avoid a repeat of early PQRI implementation  
563 experience in which problems with data reporting mechanisms and information  
564 feedback to physicians contributed to low participation rates. In 2007, only 16 percent  
565 of eligible physicians participated in the incentive program and only half of those who  
566 participated qualified for payment. Feedback was difficult to obtain and not that helpful,  
567 according to the results of one physician survey. This survey indicated that in 2008  
568 fewer than half of participating physicians succeeded in obtaining a copy of the feedback  
569 report from CMS, it took an average of nine hours to download the reports, and two-  
570 thirds of the physician sample judged the feedback reports to be unhelpful to guide  
571 improvements in care.<sup>3</sup>

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<sup>3</sup> *MGMA Physician Quality Reporting Initiative LEARN*, Medical Group Management Association, February 2010. Available online at the following URL: [http://www.mgma.com/WorkArea/mgma\\_downloadasset.aspx?id=32796](http://www.mgma.com/WorkArea/mgma_downloadasset.aspx?id=32796)

572 **V. Clarification and Technical Fixes**

573 **Recommendation 10** **Clarify eligibility rules to encourage**  
574 **participation of hospital-based physicians.**

575 **ISSUE:** The NPRM can be interpreted to state that physicians who are hospital-based  
576 will not receive EP incentives. Clarification is needed so as not to penalize physicians  
577 who provide ambulatory care from a hospital setting and/or are employed by hospitals  
578 or hospital networks. This does not imply that hospitals would be paid twice for the  
579 same thing. Rather, certain hospital-based physicians would be eligible for EP incentives  
580 for using ambulatory-oriented EHRs to meet EP Meaningful Use requirements.  
581 Hospitals would still be eligible for incentives based on meeting Meaningful Use  
582 requirements for hospitals.

583 **RECOMMENDATION:** Clarify participation of hospital-based physicians. Physicians who  
584 are hospital-employed and/or working in a hospital-based facility but primarily  
585 providing ambulatory care should be eligible for EP incentives.

586 **RATIONALE:** This clarification would recognize that different EHR and workflow  
587 capabilities and metrics are needed for outpatient and inpatient care and could avoid  
588 unintentional consequences:

- 589 • The current restriction could significantly affect safety net hospitals and the  
590 patients served by their outpatient clinics.
- 591 • Hospitals would likely choose not to make investments in Emergency  
592 Department and outpatient-oriented health IT, given that the hospital  
593 Meaningful Use requirements are inpatient-focused, and hospital-employed or  
594 hospital-based physicians engaged in Emergency Department and outpatient  
595 services would have no incentives or penalties to participate in the program.

596 **Recommendation 11** **Clarify care coordination requirements.**

597 **ISSUE:** The NPRM lists care coordination requirements that could be interpreted to  
598 depend on functionality being in place in recipient systems. There are two requirements  
599 in the care coordination section—that a summary of care record should be shared for  
600 transitions and referrals, and that a test is performed to electronically exchange key  
601 information—that, as written, may risk penalizing Doctor A’s efforts to meet the  
602 requirements because of a lack of technology or capability at Doctor B’s office.

603 **RECOMMENDATION:** Clarify the NPRM to provide flexibility so that eligible  
604 professionals and hospitals may get “credit” for coordinating care when they send

605 summary care records through channels other than direct computer-to-computer  
606 exchange among providers. In some cases, other forms of secure electronic sharing may  
607 be the most practical format for recipient systems. If the eligible provider or hospital  
608 extracts the information via qualified health IT, it should not matter in Stage 1 how the  
609 information is received by the next practice. CMS should emphasize that the goal is for  
610 information to follow the patient to the next encounter. In some cases, the most efficient  
611 means by which the information may flow to the next provider will be by providing the  
612 electronic information to the patient. (See [Recommendation 8: Allow low-burden means  
613 to achieve Stage 1 patient engagement.](#))

614 The NPRM metric requiring one test of the capacity to electronically exchange key  
615 information is not of high consequence and should be deprioritized as a noncritical  
616 process measure.

617  
618 **RATIONALE:** With regard to sharing of summary of care records, eligible professionals  
619 and hospitals in some parts of the country may have few options to exchange  
620 information electronically for care coordination if nearby practices have not adopted  
621 health IT. It is therefore important to permit flexibility on the means by which  
622 information to coordinate care is delivered.

623 Although we understand the intent behind wanting an actual metric for at least one test  
624 of electronic exchange of information, it is not well defined and therefore may invite  
625 confusion. A single successful test between any two random endpoints may not be  
626 indicative of any general capability to share information electronically in an  
627 environment where interoperability exchange standards are unevenly implemented.  
628 Rather, setting clear priorities on coordination requirements (i.e., sending summary of  
629 care records upon actual referrals or reconciling medication lists) will have more  
630 significant impact in achieving the Meaningful Use goals.

## 631 **Recommendation 12 Engage providers, patients and the public.**

632 **ISSUE:** The NPRM does not specify how Meaningful Use results will be shared, built  
633 upon or used.

634 **RECOMMENDATION:** Begin to evaluate mechanisms to use quality results to engage  
635 providers, patients and the public.

636 **RATIONALE:** Meaningful Use health objectives and results can be an important  
637 opportunity to mobilize the entire spectrum of participants in improving health care  
638 quality.

639 Please see [Appendix A, Recommendation 5](#) for additional suggested changes to clarify  
640 certain functional measures.

**These comments were jointly developed with a broad array of collaborators, including the Markle Connecting for Health Community, the Center for American Progress, and the Engelberg Center for Health Care Reform at Brookings. The comments are submitted by the following supporters:**

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# 641 Appendix A

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642 The collaborative comments outline recommendations for prioritizing, clarifying, and  
643 specifying the functional and quality measures in the NPRM. We recognize there may be  
644 several ways to accomplish the goals we have identified in our comments. For the  
645 purpose of demonstrating in greater depth how the recommendations can be applied,  
646 we offer the following specific implementation options, while also recognizing there may  
647 be other strategies that are also viable.

## 648 **Recommendation 2**                      **Prioritize quality measures.**

649 The collaborative comments recommend narrowing the lists of quality measures based  
650 on the five criteria below:

- 651        1. Favor intermediate and outcome measures.
- 652        2. Address multiple priority health goals.
- 653        3. Be “exemplar” measures that will necessitate and demonstrate the use of critical  
654            health IT functions.
- 655        4. Be “well established” and in wide use whenever possible.
- 656        5. Eliminate redundancy (e.g., remove identical measures with different thresholds,  
657            eliminate a process measure if the related intermediate outcome measure is  
658            available, eliminate EP-specific measures already addressed by core measures).

## 659 **SPECIFIC OPTION FOR CONSIDERATION**

660 The following suggests one possible way to prioritize quality measures in the NPRM  
661 using the criteria outlined above.

662 A revised set of **four core quality measures** would apply to every EP:

- 663        1. controlling high blood pressure (NQF 0018)
- 664        2. advising smokers to quit (PQRI 115, NQF 0027)
- 665        3. body mass index (BMI) screening and follow-up (PQRI 128, NQF 0421)
- 666        4. drugs to be avoided in the elderly:
  - 667            a. patients who receive at least one drug to be avoided
  - 668            b. patients who receive at least two different drugs to be avoided (NQF 0022)

669 The core set reflects key health goals outlined, including achieving healthy weight and  
670 smoking cessation as well as improving medication and chronic care management. The  
671 revisions we propose make the core measures more outcome-oriented. For instance,  
672 tracking whether blood pressure is controlled is more valuable than simply recording  
673 whether blood pressure was measured (the core metric suggested in the NPRM). While  
674 not every provider is responsible for *managing* blood pressure, every physician should  
675 be aware of this information and communicate it to patients. Likewise, identifying  
676 smokers *and also* advising them to quit is a higher value and more outcome-oriented  
677 metric than simply recording smoking status (the measure recommended in the  
678 NPRM).

679 An EP to whom one or more core measures do not apply (e.g., a radiologist who does not  
680 take blood pressure readings in the course of clinical care) can attest that one or more  
681 core measures are not relevant for his/her scope of practice. But any EP who documents  
682 these values in the context of clinical care would be expected to report the measures.

683 We suggest that EPs and hospitals be required to report the priority measures  
684 summarized in the table below, narrowed from the longer list of measures proposed in  
685 the NPRM, based on the five criteria above. It will be important to define all measures in  
686 a way that is reflective of the provider's responsibilities and the care provided to their  
687 patients (e.g., defining which patients should be included for each of the measures).

688 In addition to the core quality measures, each EP would be required to report up to five  
689 specialty-specific quality measures. Where more than five measures have been  
690 prioritized, EPs can select which five measures they will report. We agree with the  
691 recommendation in the NPRM that EPs to whom none of the specialty groups in the  
692 NPRM apply, can be exempted from reporting specialty-specific quality measures.

693 SUGGESTED PRIORITY QUALITY MEASURES

Provider Type	Health Goals	Suggested Priority Quality Measures
<p><b>Cardiology</b></p> <p>NPRM included 10 quality measures</p> <p>We suggest that 4 of those measures be prioritized and reported by physicians<sup>4</sup></p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve preventive care</li> </ul>	<ol style="list-style-type: none"> <li>1. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)</li> <li>2. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD</li> <li>3. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</li> <li>4. Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</li> </ol>
<p><b>Pulmonology</b></p> <p>NPRM included 8 quality measures</p> <p>We suggest that 3 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve preventive care</li> <li>• Increase efficiency and appropriate use of resources</li> </ul>	<ol style="list-style-type: none"> <li>1. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older</li> <li>2. Use of Appropriate Medications for People with Asthma</li> <li>3. Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy</li> </ol>
<p><b>Endocrinology</b></p> <p>NPRM included 9 quality measures</p> <p>We suggest that 5 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve chronic care management</li> <li>• Improve preventive care</li> </ul>	<ol style="list-style-type: none"> <li>1. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus</li> <li>2. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus</li> <li>3. Comprehensive Diabetes Care: HbA1c Control (&lt;8.0 percent)</li> <li>4. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient</li> <li>5. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</li> </ol>

<sup>4</sup> PQRI 128 (BMI) lists “follow-up plan”; more specificity is required. Additionally, ‘Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol’ (PQRI 197) is listed in the proposed rule as appearing in both the Cardiology and Primary Care measure groups. It appears that this measure, while included in Primary Care, was mistakenly removed and should be included for Cardiology.



Provider Type	Health Goals	Suggested Priority Quality Measures
<p><b>Oncology</b></p> <p>NPRM included 6 quality measures</p> <p>We suggest that all six of those measures be prioritized</p> <p>Physicians can select five of the 6 priority measures to report in Stage 1</p> <p>We suggest retaining the first three measures if they can be clarified as “surveillance”. If that is not possible, we suggest eliminating them as measures for oncology.</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve preventive care</li> <li>• Increase efficiency and appropriate use of resources</li> </ul>	<ol style="list-style-type: none"> <li>1. Preventive Care and Screening: Screening Mammography</li> <li>2. Preventive Care and Screening: Colorectal Cancer Screening</li> <li>3. Cervical Cancer Screening</li> <li>4. Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer</li> <li>5. Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients</li> <li>6. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients</li> </ol>
<p><b>Surgery</b></p> <p>NPRM included 6 quality measures</p> <p>We suggest that 3 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Reduce hospital readmissions</li> <li>• Improve patient safety</li> </ul>	<ol style="list-style-type: none"> <li>1. Surgical Site Infection Rate</li> <li>2. 30-day Readmission Rate</li> <li>3. Perioperative Care: Selection of Prophylactic Antibiotic, First OR Second Generation Cephalosporin</li> </ol>

Provider Type	Health Goals	Suggested Priority Quality Measures
<p><b>Primary care</b></p> <p>NPRM included 29 quality measures</p> <p>We suggest that 7 of those measures be prioritized</p> <p>Primary care physicians can select 5 of the 7 priority measures to report in Stage 1</p> <p>Primary care physicians serving both children and adults can report a mix of primary care and pediatrics measures reflecting their patient mix.</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve chronic care management</li> <li>• Improve preventive care</li> </ul>	<ol style="list-style-type: none"> <li>1. Ischemic Vascular Disease (IVD) Low-Density Lipoprotein Control</li> <li>2. Comprehensive Diabetes Care: HbA1c control (&lt;8 percent)</li> <li>3. Preventive Care and Screening: Screening Mammography</li> <li>4. Preventive Care and Screening: Colorectal Cancer Screening</li> <li>5. Cervical Cancer Screening</li> <li>6. Ischemic Vascular Disease: Use of Aspirin or other Antithrombotic</li> <li>7. Use of Appropriate Medications for People with Asthma</li> </ol>
<p><b>Pediatrics</b></p> <p>NPRM included 9 quality measures</p> <p>We suggest that 4 of those measures be prioritized and reported by physicians</p> <p>*We also recommend the addition of one measure not included in the pediatrics list in the NPRM: use of appropriate medications for people with asthma</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Increase efficiency and appropriate use of resources</li> <li>• Improve preventive care</li> </ul>	<ol style="list-style-type: none"> <li>1. Appropriate Testing for Children with Pharyngitis</li> <li>2. ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</li> <li>3. Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Antibiotic Use</li> <li>4. Childhood Immunization Status</li> <li>5. *Use of Appropriate Medications for People with Asthma<sup>5</sup></li> </ol>

<sup>5</sup> We suggest that this asthma measure from Primary Care be added to Pediatrics and prioritized.

Provider Type	Health Goals	Suggested Priority Quality Measures
<p><b>Obstetrics and Gynecology</b></p> <p>NPRM included 9 quality measures</p> <p>We suggest that 5 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Increase efficiency and appropriate use of resources</li> <li>• Improve preventive care</li> <li>• Reduce hospital readmissions</li> </ul>	<ol style="list-style-type: none"> <li>1. Chlamydia Screening in Women</li> <li>2. 30-day Readmission Rate following deliveries</li> <li>3. Cesarean Rate for Low-risk First Birth Women (aka NTSV CS rate)</li> <li>4. Cervical Cancer Screening</li> <li>5. Preventive Care and Screening: Screening Mammography</li> </ol>
<p><b>Neurology</b></p> <p>NPRM included 5 quality measures</p> <p>We suggest that 4 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve chronic care management</li> </ul>	<ol style="list-style-type: none"> <li>1. Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control</li> <li>2. Ischemic Vascular Disease (IVD): Blood Pressure Management Control</li> <li>3. Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge</li> <li>4. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</li> </ol>
<p><b>Psychiatry</b></p> <p>NPRM included 6 quality measures</p> <p>We suggest that 5 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve preventive care</li> </ul>	<ol style="list-style-type: none"> <li>1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement</li> <li>2. New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment</li> <li>3. Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD</li> <li>4. Major Depressive Disorder (MDD): Diagnostic Evaluation</li> <li>5. Major Depressive Disorder (MDD): Suicide Risk Assessment</li> </ol>

Provider Type	Health Goals	Suggested Priority Quality Measures
<p><b>Radiology</b></p> <p>NPRM included 7 quality measures</p> <p>We suggest that 2 of those measures be prioritized and reported by physicians<sup>6</sup></p>		<ol style="list-style-type: none"> <li>1. Radiology: Exposure Time Reported for Procedures Using Fluoroscopy</li> <li>2. Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening</li> </ol>
<p><b>Ophthalmology</b></p> <p>NPRM included 3 quality measures</p> <p>We suggest that all 3 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve chronic care management</li> </ul>	<ol style="list-style-type: none"> <li>1. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</li> <li>2. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</li> <li>3. Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care</li> </ol>
<p><b>Podiatry</b></p> <p>NPRM included 3 quality measures</p> <p>We suggest that all 3 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve chronic care management</li> </ul>	<ol style="list-style-type: none"> <li>1. Diabetes Mellitus: Foot Exam</li> <li>2. Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention, Evaluation of Footwear</li> <li>3. Diabetic Foot Care and Patient Education Implemented</li> </ol>
<p><b>Gastroenterology</b></p> <p>NPRM included 6 quality measures</p> <p>We suggest that 5 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve preventive care</li> <li>• Increase efficiency and appropriate use of resources</li> <li>• Improve chronic care management</li> </ul>	<ol style="list-style-type: none"> <li>1. Preventive Care and Screening: Colorectal Cancer Screening</li> <li>2. Hepatitis C: Antiviral Treatment Prescribed</li> <li>3. Hepatitis C: Hepatitis A Vaccination in Patients with HCV</li> <li>4. Hepatitis C: Hepatitis B Vaccination in Patients with HCV</li> <li>5. Endoscopy &amp; Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps, Avoidance of Inappropriate Use</li> </ol>

<sup>6</sup> While imaging for low back pain is a good efficiency measure, this is not an appropriate measure for radiologists as they carry out but do not order these tests

Provider Type	Health Goals	Suggested Priority Quality Measures
<p><b>Nephrology</b> NPRM included 6 quality measures We suggest that 4 of those measures be prioritized and reported by physicians</p>	<ul style="list-style-type: none"> <li>• Improve medication management</li> <li>• Improve chronic care management</li> </ul>	<ol style="list-style-type: none"> <li>1. Chronic Kidney Disease (CKD): Blood Pressure Management</li> <li>2. End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients</li> <li>3. End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis</li> <li>4. Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)</li> </ol>
<p><b>Hospitals</b> NPRM included 35 quality measures We suggest that 11 of those measures be prioritized and reported by hospitals</p>	<ul style="list-style-type: none"> <li>• Reduce readmissions<sup>7</sup></li> <li>• Improve patient safety</li> </ul>	<ol style="list-style-type: none"> <li>1. Hospital Specific 30-day Readmission Rate following AMI Admission</li> <li>2. Hospital Specific 30-day Readmission Rate following Heart Failure Admission</li> <li>3. Hospital Specific 30-day Readmission Rate following Pneumonia Admission</li> <li>4. Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients</li> <li>5. Primary PCI Received Within 90 Minutes of Hospital Arrival</li> <li>6. Emergency Department Throughput—admitted patients median time from ED arrival to ED departure for admitted patients</li> <li>7. Emergency Department Throughput—admitted patients Admission decision time to ED departure time for admitted patients</li> <li>8. Emergency Department Throughput—discharged patients median Time from ED Arrival to ED Departure for Discharged ED Patients</li> <li>9. Incidence of potentially preventable VTE</li> <li>10. Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients</li> <li>11. Central line catheter-associated blood stream infection rate for ICU and high-risk nursery (HRN) patients</li> </ol>

<sup>7</sup> Readmission rates reported by hospitals will reflect patients discharged from and readmitted to that hospital. Hospitals are not obligated to seek readmission information from other hospitals.

694 **Recommendation 4** **Re-evaluate the all-or-none payment**  
695 **approach.**

696 The collaborative comments recommend that CMS should allow EPs and hospitals to  
697 qualify for incentive payments for achieving a high proportion of, but not all, measures  
698 in 2011.

699 **SPECIFIC OPTION FOR CONSIDERATION**

700 The following specific suggestions outline one possible way to allow EPs and hospitals to  
701 achieve Meaningful Use by meeting the majority of Meaningful Use measures in the first  
702 year.

703 Given their foundational importance to Meaningful Use and quality improvement and  
704 reporting, reporting of certain measures should be mandatory.<sup>8</sup>

- 705 • We recommend that some measures (**13 for EPs and 11 for hospitals**) be  
706 required of all applicable providers, including reporting quality results, clinical  
707 lists, patient engagement measures, and risk assessment. As shown in the table  
708 below, the mandatory list includes at least one measure from each Meaningful  
709 Use category, except improving population and public health.
- 710 • **EPs and hospitals would be required to meet at least 7 of the**  
711 **remaining measures** (see table below).

712 This approach eliminates the requirement to report any measure that is impossible to  
713 achieve given conditions external or outside the influence of the practice (e.g., a test of  
714 sending reportable labs was not possible because the state public health department had  
715 not established the needed interfaces).

716

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<sup>8</sup> As proposed in the NPRM, in Stage 1, all results will be demonstrated through attestation except the quality measures in 2012.

717 The table includes all Meaningful Use criteria included in the NPRM, organized by the  
 718 five policy priorities (e.g., improving quality, engage patients, etc.) used in the  
 719 regulations.

<b>EPs and hospitals that meet all mandatory measures and seven of the remaining measures would be eligible for incentives in the first year</b>	
<b>Mandatory measures (13 for EPs, 11 for hospitals)</b>	<b>Providers must meet 7 of remaining measures</b>
<b>Improving Quality, Safety, Efficiency and Reducing Health Disparities</b>	
<ul style="list-style-type: none"> <li>• Demographics</li> <li>• Problem list</li> <li>• Active medication list</li> <li>• Active medication allergy list</li> <li>• Vitals</li> <li>• E-prescribing (EP only)</li> <li>• Drug-drug/drug-allergy checks</li> <li>• Reporting quality results</li> </ul>	<ul style="list-style-type: none"> <li>• Smoking status</li> <li>• Reminders (EP only)</li> <li>• Clinical decision support</li> <li>• CPOE</li> <li>• Structured lab data</li> <li>• Electronic insurance eligibility</li> <li>• Electronic claims</li> <li>• Lists of patients with specific conditions</li> </ul>
<b>Engage Patients and Families in their Health Care</b>	
<ul style="list-style-type: none"> <li>• Provide patients with timely electronic access to health information (EP only)</li> <li>• Provide patients with electronic copies of their health information</li> <li>• Provide patients with clinical summaries/discharge instructions</li> </ul>	
<b>Improve Care Coordination</b>	
<ul style="list-style-type: none"> <li>• Summary of care record at transitions/referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Medication reconciliation</li> <li>• Electronic exchange of clinical data</li> </ul>
<b>Improve Population and Public Health</b>	
	<ul style="list-style-type: none"> <li>• Electronic syndromic surveillance</li> <li>• Reportable lab results to public health agencies (Hospital only)</li> <li>• Immunization registries</li> </ul>
<b>Ensure Adequate Privacy and Security Protections for Personal Health Information</b>	
<ul style="list-style-type: none"> <li>• Risk analysis</li> </ul>	

720

721 Any measure not met in the first reporting year would need to be met in the second  
 722 reporting year.

723 In recommendation 5 below (Simplify and Focus the Functional Measures to Reduce  
 724 Reporting Burden) we discuss reducing reporting burden on providers by requiring that

725 values be calculated (using numerator/denominator) and specific thresholds be met  
726 only for certain measures.

727 **Recommendation 5**                      **Simplify and streamline the functional**  
728    **measures.**

729 The collaborative comments recommend simplifying the functional measures to reduce  
730 burden and de-emphasize process reporting and propose that the requirement to report  
731 a calculated numerator/denominator and achieve specific performance thresholds  
732 should only be retained for functional measures:

- 733            • in areas that are clearly aligned with health goals and where intermediate or  
734            outcome measures are lacking
- 735            • that are foundational to tracking, improving, and reporting quality of care for  
736            groups of patients (e.g., vitals, demographics, problem list, medication list,  
737            medication allergies)
- 738            • that can be reported directly from electronic systems, without manual counts

739 **SPECIFIC OPTION FOR CONSIDERATION**

740 The following specific suggestions outline one possible way to simplify the functional  
741 measures in the NPRM using the criteria.

742 **We suggest retaining numerator/denominator reporting and performance**  
743 **thresholds for the following functional measures for Stage 1**, to be phased out  
744 in Stage 2. All of these measures are also included in the mandatory reporting set,  
745 outlined in Recommendation 4 (Re-evaluate the All-or-None Payment Approach).

- 746            • Problem list
- 747            • Vitals
- 748            • Active medication list
- 749            • Active medication allergy list
- 750            • Demographics
- 751            • Summary of care record at transitions/referrals

752 The performance thresholds for these measures should be lowered in the first year and  
753 may be increased to 80 percent in year two.

754 Please see Recommendation 8 (Allow Low-Burden Means to Achieve Stage 1 Patient  
755 Engagement) for specific recommendations for patient engagement requirements (i.e.,  
756 clinical summaries to patients after visits/electronic discharge instructions, copies of



757 electronic information and electronic access). In these areas we recommend that basic  
758 counts replace calculation and reporting of threshold levels to maintain strong focus on  
759 these information sharing requirements but avoid cumbersome manual tracking and  
760 uncertainty about the denominators that need to be addressed.

761 Quality results will also be reported using numerators and denominators but no  
762 thresholds. Quality reporting should continue in all phases of Meaningful Use.

763 For Stage 1, providers should be able to satisfy the remaining functional measures for  
764 which the NPRM currently requires numerators/denominators and performance  
765 thresholds by attesting that they have and routinely use the function, subject to audit. If  
766 audited, providers would be required to demonstrate use of the function that formed the  
767 basis of the attestation. This approach signals that the functions are important and  
768 should be used to achieve Meaningful Use, without requiring detailed and burdensome  
769 reporting:

- 770 • Smoking status
- 771 • CPOE
- 772 • E-prescribing
- 773 • Structured lab data
- 774 • Electronic insurance eligibility
- 775 • E-claims
- 776 • Reminders
- 777 • Medication reconciliation
- 778

## 779 **Clarifications and Fixes**

### 780 **SPECIFIC OPTION FOR CONSIDERATION**

781 The following revisions to functional measures will clarify these requirements:

- 782 • Electronic hospital discharge instructions should be routinely offered to patients  
783 at discharge rather than being supplied only on request.
- 784 • EPs should determine the age and target group for preventive care reminders  
785 based on their patient populations (not simply all patients seen during a measure  
786 year) and the quality measures they report, rather than sending reminders only  
787 for patients over 50 years old. Reminders can include prompts for follow-up care,  
788 as preventive care reminders may not be relevant or appropriate for all  
789 specialties.

- 790 • Documentation of advance directives should be a requirement for Meaningful  
791 Use for hospitals. Maintaining these preferences in hospital electronic systems  
792 may make it easier for providers to support patient choices and more likely that  
793 those preferences will be followed.
- 794 • To satisfy the privacy and security requirements of Meaningful Use, providers  
795 should complete a risk analysis and mitigate any risks identified, including  
796 addressing any deficiencies in use of the security capabilities identified in the IFR  
797 (e.g., encryption, audit trail, etc.).
- 798 • The problem list is currently defined as including current/active diagnoses as  
799 well as past diagnoses relevant to the care of the patient. While some providers  
800 use a problem list in this fashion, many include ONLY current/active diagnoses,  
801 and use a separate “Past Medical History” field for prior relevant diagnoses. The  
802 NPRM should not attempt to redefine these accepted practices. The NPRM also  
803 mentions that the word “none” should be recorded as structured data if there are  
804 no active problems in the problem list. While “none” can be displayed in the field  
805 where appropriate, it is not a structured entry for a coded problem list.
- 806 • Medication reconciliation is defined as comparing two medication lists. This is  
807 valid ONLY when medication reconciliation is done between two settings of care,  
808 which would be the minority of time that EPs would perform medication  
809 reconciliation. Medication reconciliation should be clarified as either comparing  
810 two lists when the patient changes settings of care, OR verifying the active  
811 medication list when the patient is within the same setting of care.
- 812 • BMI for ages 2 to 18 is currently defined as requiring a BMI *and* a printed growth  
813 chart. As the printing of a growth chart may be difficult to track electronically, it  
814 is recommended that this be redefined as BMI and a printed growth chart if  
815 available, or BMI and the BMI percentile.
- 816 • Demographics for hospitals should ONLY include the date and cause of death  
817 when the patient dies during a hospitalization.
- 818 • The capability for the EHR to generate lists of patients is described as both a  
819 function for EPs and hospitals. However, the clinical relevance of this metric for  
820 hospitals is not clear and should be clarified by CMS. If not clarified, it should be  
821 removed from consideration for hospitals.
- 822 • The summary of care record (for transitions of care) is defined as being either a  
823 CCD or CCR document, but the clinical fields contained within the summary of  
824 care record are not defined, and should either be defined or clarified as left to the  
825 discretion of the provider/hospital.

826 • The implementation of drug-drug and drug-allergy checking is currently  
827 described as including the ability of certain users to “deactivate, modify, and add  
828 rules...” Most such systems allow administrative users the right ONLY to set the  
829 threshold level of checking, and modify the content of the alerts. This should be  
830 clarified by CMS.

831 • The metric for maintenance of the medication allergy list includes the phrase  
832 “medication allergy history.” Such a term has significance for medication history,  
833 but there is no parallel application yet for medication allergies. This should be  
834 clarified by CMS. This metric also states that the word “none” should be used if  
835 there are no medication allergies. Current medical practice is to use the term  
836 NKMA or NKDA, and the definition should be expanded to include these terms.