May 22, 2015

Karen DeSalvo, MD
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. DeSalvo:

The Health IT Policy Committee gave the following charge to the Interoperability and Health Information Exchange Workgroup:

- The Interoperability and HIE Workgroup will recommend policy and promote opportunities to reduce barriers and to increase electronic sharing of health information among providers, organizations, and patients/caregivers.
- The workgroup will use implementation lessons learned
- The work group will align efforts with the Privacy and Security Workgroup and the Health IT Standards Committee.
- The workgroup will make recommendations that focus on policies that can help address implementation challenges.
- The workgroup will promote a business and regulatory environment supportive of widespread information exchange.

This transmittal letter reflects comments on the Meaningful Use Stage 3 NPRM that were presented to and approved by the Health IT Policy Committee on May 22, 2015

Comments on the Meaningful Stage 3 NPRM

General Comments

1. **In general, the IOWG agrees with the direction and goals of the Objective 7 measures**
   - Important for quality and safety
   - HIE functions are gaining traction in the market, and these objectives are good impetus to keep progressing

2. **However, we are concerned about setting thresholds that are unrealistically high**
   - We agree with setting higher thresholds
   - However, we don't want to have to backtrack on the threshold, as has happened with VDT

- Want to motivate providers to "own the problem", but not penalize them for factors that are genuinely out of their control

3. **Can balance thresholds with judicious allowance for exclusions**
   - May want to consider trade-offs between thresholds and exclusions
   - Keep threshold high if also allowing exclusions, or conversely, lower threshold if not allowing exclusions

Measure 1 Comments

1. **Lower threshold to 40%**
   - Stage 2 data suggests that average provider will be well below 50%
   - 2014 exclusion allowance (by which 86% of EPs avoided the TOC requirement) has slowed market adoption of TOC functions
   - However, want to keep rate high to motivate forward progress

2. **Allow any electronic transport**
   - Industry challenges with Direct could be barrier to achievement in many markets (also, see recommendation on HIE governance)
   - Gives credit to those who have other types of HIE capabilities

3. **Allow patient self-referrals**
   - IOWG is concerned that the measure adds workflow burden which, without automated HIE functions, offers little benefit to patient care
   - However, inclusion encourages use of automated HIE functions such as automated response to utilization alerts or electronic query

4. **Do not allow "selfies"**
   - Disproportionately favors integrated delivery networks
   - "Selfies" do not add to patient care – information already available in EHR and in most cases is accessed that way

5. **Allow flexibility in CCDS payload**
   - In many transition or referral use cases, it is not clinically beneficial to provide the entire CCDS
   - Contributes to "CCDA bloat", which many providers note makes CCDAs unusable
   - Allow provider discretion, as is proposed for labs and clinical notes, rather than requiring that all CCDS elements be populated if available

6. **Allow exclusion for <100 transitions/referrals**
   - Cost of implementing electronic capabilities for <100 transitions/referrals per year outweighs clinical and efficiency benefits to patients
   - Any future adjustments to reporting periods should adjust inclusion/exclusion thresholds as well

7. **Do not allow exclusion for low broadband penetration**
   - This exclusion appropriate for patient engagement measures but not for measures of provider-provider exchange

- There may be circumstances where electronic exchange is not dense enough to allow a provider to meet measure threshold
- IOWG did consider recommending an "ecosystem" exclusion to address such cases, however, we were not able to come up with an approach that didn't add more complexity than it solved
- We do recommend that CMS monitor this issue carefully and consider such an exclusion in the future if the problem appears significant and beyond the control of EPs and EHs in certain markets (e.g., exclusion if large fraction of transitions/referrals go to settings that are not EPs or EHs)

Measure 2 Comments

1. **Change threshold to: incorporate any type of information for XX% of TOCs/referrals or never before encountered patients, and CCDAs for YY% of TOCs/referrals or never before encountered patients**
   - Reconciling these measures is not straightforward because they apply to different types of information from different types of providers for different groups of patients. While we did not have time to get consensus on a specific recommendation that merges the measures, we do recommend that CMS use the following principles in doing so:
   - Merge with Measure 2 as recommended
   - Do not set separate targets for "non-clinical providers" (e.g., separate measure or X% for all providers, Y% for "non-clinical providers")
   - Set a two-tier objective, with a higher threshold with greater content/format flexibility and a lower threshold based on CCDAs (e.g., incorporate any type and format of clinically relevant information for 25% of TOCs/referrals, incorporate CCDAs for 15% of TOCs/referrals)
   - Retain TOCs/referrals + never before encountered + electronically queried as denominator
   - Require electronic means of transmission
   - Allow exclusion for "electronic means not available"
   - Allow incorporation of electronically queried information outside of specific episodes of care
   - Clearly define the meaning of "incorporate" for CCDA and non-CCDA information

2. **Allow for provider discretion in what to incorporate**
   - Draft rule requires "incorporate" if available
   - Addresses concern about "CCDA bloat" – complements discretion allowed in Measure 1
   - Also recommend that CMS clearly define "incorporate" vs "reconcile"

3. **Allow for "active" or "passive" receipt; allow any type of query**
   - Good first step to enabling fully electronic query capability
   - With no widely available, mature standards for query, and no ecosystem to support such exchange, flexibility is required
   - Gives credit to those who are in data sharing arrangements with electronic query or record location services

4. **Allow "never before encountered"**
   - IOWG is concerned that the measure adds workflow burden which, without automated HIE functions, offers little benefit to patient care

- However, inclusion encourages use of automated HIE functions such as automated response to utilization alerts or electronic query
- Recommend that CMS define "never before encountered" to mean "no record in EHR" – covers cases where patient sees new EP in same clinical organization

5. **Allow exclusion for "information unavailable" (agree with NPRM)**
   - Ecosystem maturity will take time so need to accommodate such exceptions if we keep a high 25% threshold on a new measure
   - Should define HIE availability as: "Query capability has been in production and functionally available through the entire reporting period, as attested to by provider"

6. **Allow for queries outside of specific transition/referral episodes (disagree with NPRM)**
   - Population health management is increasing demand for information outside of discrete episodes of care
   - Including information received from queries outside of specific transitions/referrals encourages use of advanced HIE functions and promotes cognitive activities such as care planning and care coordination
   - Including such queries does require adjustment of measure definition – how to determine the denominator for discretionary queries?
   - For measure, allow EP/EH discretion on which queries are clinically appropriate and include in numerator and denominator
   - Within an EP practice, give MU credit to any EP who has seen patient (preferred), or to PCP, or to last EP to have seen patient

7. **Do not allow "utilization alerts"**
   - Too complex to determine "qualifying alert"
     - Not all alerts are related to transitions/referrals for a particular EP/EH
     - Multiple alerts often generated in a single episode of care
   - Utilization alerts typically contain very little, if any, clinical information

8. **Do not allow exclusion for low broadband penetration**
   - This exclusion is appropriate for patient engagement measures but not for measures of provider-provider exchange

Measure 3 Comments

1. **Set threshold at 80% for medications and medication allergies**
   - The IOWG believes that information reconciliation should be done 100% of the time, however, need to account for practical reasons where it may not be possible or clinically appropriate
   - The IOWG is concerned with setting such a high threshold for reconciliation while the thresholds for sending (Measure 1) are much lower
   - However, we agree with CMS that reconciliation is critically important
   - We believe that meds and meds allergies are sufficiently well-defined, and there is enough flexibility in how reconciliation can be performed to meet the requirement, that it is appropriate to set a high goal in these areas

2. **Lower threshold for problems to 10%, or make problems optional**

- The IOWG is concerned with expanding the scope to problems at such a high threshold
- Problem reconciliation is operationally very difficult and different in nature from meds and meds allergies reconciliation
    - Patients can report meds and med allergies in most cases, however, they are less able to reliably report on diagnoses
    - There is ambiguity in coding conventions – multiple ICD codes can cover single experience of illness
    - Providers vary widely in their approach to problem lists – "lumpers versus splitters", active versus inactive, etc
- Agree that it should be done over time and thus IOWG recommends including it at low level to give CMS opportunity to increase it over time

3. **Remove "never before encountered" from denominator**
    - With new patients there is nothing to reconcile against
    - Recommend that CMS define "never before encountered" to mean "no record in EHR" – covers cases where patient sees new EP in same clinical organization

4. **Allow either automated or manual reconciliation**
    - There is still too much variation in quality of structured data to require automated reconciliation

5. **IOWG did not reach consensus on if credentialed MAs should be allowed to perform reconciliation**
    - IOWG believes that providers should have flexibility to delegate work as clinically appropriate and as allowed by State law
    - However, some members of the IOWG remain concerned that MAs may not be qualified to perform some reconciliation such as problems
    - The IOWG recommends that CMS emphasize that providers are responsible for ensuring that staff are fully qualified and diligently supervised if they are allowed to perform reconciliation functions

6. **Allow exclusions for some specialists**
    - High levels of reconciliation is not appropriate for some specialties with narrow scopes of practice (e.g., low prescribers, orthopedists for whom problem list reconciliation is not clinically relevant, information not available due to narrow scope of practice, etc)
    - There are no "low volume" exclusions allowed for Measure 3
    - The IOWG recommends that CMS include exclusions for specialties where it may not be clinically relevant or practically possible to achieve high rates of formal reconciliation.

7. **CMS should clarify that reconciliation occurring prior to a patient visit counts towards the numerator.**

We appreciate the opportunity to provide these recommendations and look forward to discussing next steps.

Sincerely yours,

/s/

Paul Tang
Vice Chair, Health IT Policy Committee