



January 1, 2011

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National Coordinator for Health Information Technology
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, S.W.
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Dear Dr. Blumenthal and Dr. Berwick,

The Patient Centered Primary Care Collaborative (PCPCC) is a coalition of more than 700 employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians and others who have joined together to develop and advance the patient centered medical home (PCMH), which has shown great potential in multiple demonstration projects throughout the country towards the common goals of improving care quality and reducing cost. We have previously provided input into the development of Stage 1 requirements for meaningful use, and are writing to provide recommendations on the approach to Stage 2 and 3, in the context of some initial reflections on Stage 1. We have been tracking the presentations of the Meaningful Use Workgroup at the HIT Policy Committee, including at the December meeting, and intend to submit a follow up letter in response to your planned release of a document for comment in January.

Stage 1

We have previously commended the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for HIT (ONC) for Stage 1 meaningful use (MU) requirements. We believe that they are directionally correct, and are aiming to support the transformation of healthcare delivery in ways that are consistent with the patient-centered primary care that is the hallmark of the PCMH model.

Within that context, however, we believe that three aspects of the current requirements deserve further comment.

First, one of the potential benefits of the MU requirements is their ability to drive development and availability of the HIT which is required to enable the healthcare transformation that is hoped for. Some of the Stage 1 requirements, and the associated requirements for certification of electronic health records (EHRs), promote availability of HIT that is needed for PCMH transformation. Examples include the capture of information in an EHR, e-prescribing, registry functionality, and generation of clinical summaries. For PCMH transformation to be fully realized, however, more substantial HIT availability is needed. This will be discussed further in comments on Stages 2 and 3.

Second, one of the potential problems with MU requirements is that they are distinct from other requirement sets that apply to healthcare providers. For primary care physicians, such requirement sets include those of other payers for performance-based payment—particularly as PCMHs—and those related to licensure and maintenance of specialty certification. Insofar as these requirement sets are not consistent with each other, they create confusion and unnecessary work for providers. In our comments on proposed Stage 1 requirements, we advocated for their congruence with PCMH recognition. We are pleased to note that a subset of NCQA's PCMH recognition requirements beginning in 2011 will be consistent with those of the MU, where the requirements relate to similar capabilities. This is a good first step toward the type of alignment that is needed to support effective transformation.

Third, another potential difficulty with MU requirements is that they require primary care physicians to do additional work to document compliance with them. In our comments on proposed Stage 1 requirements, we advocated for enabling documentation to be based entirely on reporting that can come directly from a certified EHR. We were pleased to see that many of the final requirements enable this, although in the first year of the program, reporting will not be electronic. We encourage continued work to make sure all reporting can come directly from certified EHR technology.

Stages 2-3

The metaphor that has been used for Stage 1 is that the requirements are such that many providers will be willing to get on the “escalator” of meaningful use. As discussed above, we believe that this has been accomplished. In our view, however, it is important for Stage 2 and 3 requirements to result in material transformational change for those ascending and eventually emerging from the escalator. This can be accomplished by creating requirements that are appropriately rigorous and effective in improving outcomes but that can also be documented in a way that is simple, and is consistent with other regulatory and reform programs.

As with Stage 1, our comments are in three areas.

First, Stage 2 and 3 requirements must drive even more strongly the development and availability of HIT to support PCMH transformation. Current EHRs were developed largely for purposes of supporting and documenting visit-based care. Although Stage 1 requirements begin to move EHR technology in the right direction, more substantial changes in HIT are required to support proactive, patient-centered, coordinated care. These changes include:

- Clinical decision support – ability to prompt for needed information relative to clinical decisions and provide guidelines/evidence-based support for treatment plans and for identification of and outreach to patients needing services related to clinical conditions and preventive care
- Care planning – ability to generate care plans based on patient preferences, track implementation of activities agreed to by the provider/care manager and the patient, and prompt for and accept patient self-monitored data
- Informed decision-making – ability to provide patients with tailored information and interactive support for decisions about the treatment plan based on patient profile, diagnosis, and risk factors.
- Patient Health Record (PHR) – ability of the patient to have electronic access to their medical record, as well as the ability to download an electronic copy of key personal health information (clinical results, care plan), to access informed decision-making support, to generate self-monitored results in support of a care plan, to determine what information is shared with providers
- Patient experience reporting – ability of the patient to report on well-being and functional status and the experience of receiving care and self-management support
- Care coordination – ability to exchange key documents (lab results, consultation requests and reports, care plans, discharge summaries) among providers
- Population health – ability to report key clinical, behavioral, well-being, and functional parameters to state/local public health agencies, with appropriate privacy and security safeguards

The HIT Policy Committee has proposed moving to a focus on outcomes in Stage 3, with Stage 2 being transitional from the process-oriented focus of Stage 1. An advantage of this is that it makes payment directly dependent on outcomes, and therefore on value creation. It also creates flexibility for providers in determining how to achieve outcomes, which supports innovation and customization. A disadvantage of this is that it may not create specific guidance or solutions for providers about how to achieve outcomes. Requirements focused on outcomes may not identify effective ideas and assistance for how to transform care, or drive the availability of standardized, affordable, scalable HIT solutions. Additionally, outcomes measures require risk adjustment, and current risk adjustment methods available to providers using EHRs may not be adequate to adjust for population differences among providers.

Given these considerations, we have four recommendations:

- Although outcomes are an appropriate focus for Stage 3, we recommend giving consideration to how they are risk-adjusted, and balancing them with some continued process-oriented measures. A method of accomplishing this that is particularly appropriate from a PCMH perspective is to include in Stages 2 and 3 measures of patient-reported outcomes that reflect their experience of receiving care and resulting ability to self-manage. Examples of such measures could include whether the patient received support for decision-making and care planning that included assessment of their preferences. Properly constructed measures of this type will direct providers to use effective systems and processes. We are pleased to see that the Quality Measures Workgroup of the HIT Policy Committee is exploring measure concepts related to patient and family engagement that could capture the needed information.
- Develop a plan for achieving the full range of HIT capabilities needed to support proactive, patient-centered, coordinated care. This would include a specification of the functionalities and data standards needed, and the process for promoting their development. In order to assist your consideration of using Stage 2-3 MU and EHR certification requirements to support implementation of this plan, we have included as an appendix a table that shows specific functionalities that we believe are needed for PCMHs, as well as ACOs, and population health organizations, whether they are included in Stage 1, and proposed measures for inclusion in Stages 2-3.
- In conjunction with expanding the certification requirements for EHRs to include additional components needed for PCMH, create a mechanism for assessing the usability of HIT components in supporting processes needed to achieve the specified outcomes. A specific example would be to identify the processes for which there is best evidence of prevention of readmission through transitions management, and assess the usability of certified EHRs in enabling these processes.
- Assure availability of health information exchange (HIE) mechanisms to support MU and PCMH.

Second, as alluded to above, we recommend that the Stage 2 and 3 requirements be further aligned with those of other health reform related regulations and programs. Specifically, we recommend that be a core set of requirements and measures that are common to programs including:

- Other CMS programs: PCMH, ACO, and those tested by the Center for Medicare and Medicaid Innovation (CMMI)
- Other payer performance-based payment programs that include PCMH
- Specialty maintenance of certification programs

Third, we recommend that the core set of meaningful use requirements that are common with other payment and certification programs be reportable directly by certified EHRs and patient experience surveys without additional documentation effort.

In conclusion, we again commend the ONC and CMS for the work that has been done to advance patient care through the meaningful use program. We believe that the opportunities for Stages 2 are 3 and great, but given the need for transformational change and HIT support for it, we are mindful of the challenges involved. We hope that this letter is helpful in identifying some of the directions that are needed going forward.

Sincerely,

A handwritten signature in cursive script that reads "Edwina Rogers".

Edwina Rogers
Executive Director
Patient Centered Primary Care Collaborative