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May 26, 2015

Submitted Electronically

Acting Administrator Andrew Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
Washington, D.C. 20201

RE: Medicare and Medicaid EHR Incentive Program-Stage 3 (CMS-3310-P)

Dear Acting Administrator Slavitt:

On behalf of the members of the American Health Information Management Association (AHIMA), we are pleased to submit comments related to the Notice of Proposed Rulemaking (NPRM) for Stage 3 Meaningful Use for CMS' EHR Incentive Program. AHIMA is a not-for-profit, membership-based healthcare association representing more than 101,000 health information management (HIM) and informatics professionals who work in more than 40 different types of entities related to our nation's healthcare and public health industry. Many of our members' daily work involves an ongoing commitment to ensuring the integrity of the data and information in EHRs to support patient safety and quality care as well as payment, legal, and regulatory purposes.

AHIMA strongly supports the stated goals of the Stage 3 NPRM of providing a flexible, clear framework to simplify the meaningful use program and reduce provider burden; ensuring future sustainability of the EHR incentive programs; and advancing the use of health IT to promote health information exchange and improve patient outcomes. We believe that the NPRM makes significant progress toward achieving these goals.

Our comments focus on selected stage 3 MU proposed objectives. We do not comment specifically on the appropriateness of threshold rates for each measure, but strongly recommend that data indicating experience with Stage 2 measures, where appropriate, be carefully evaluated before finalizing Stage 3 threshold rates in order to assure they are reasonable and achievable by eligible professionals and hospitals.

Objective 1- Protect electronic health information

As noted in the NPRM, protection of ePHI remains essential to all aspects of the Meaningful Use program. AHIMA supports the requirement for the security risk analysis to be conducted at a minimum of once per EHR reporting period as well as the proposed inclusion of administrative and physical safeguards in addition to existing requirements for technical safeguards. AHIMA also supports the requirement for providers to conduct the security risk analysis upon installation of CEHRT or upon upgrade to a new edition of CEHRT.

Objective 5—Patient Electronic Access to Health Information

This objective identifies a policy goal of providing timely access by patients "to their full health record and related important health information" in order to be able to "engage in patient-centered communication for care planning and care coordination." We fully support this policy goal, but believe the objective and associated measures identified are focused on the technology that provides this accessibility and do not adequately describe the full health record. As stated, the objective includes "patient reminders, patient specific resources, clinical summaries of office visits, secure messaging, and the ability for patients to view, download, and securely transmit to a third party." We propose that this objective should include any relevant, clinical information contained in the EHR that would support the patient's ongoing care and treatment. In addition to the information listed above, we recommend specifically including clinical notes. Evidence[1] from projects such as OpenNotes demonstrates quantifiable benefits to patients who have access to this information. Sharing of relevant clinical information in the health record is necessary if we are to seriously engage patients in their healthcare. Metadata and administrative data should not be considered part of the "full health record". There needs to be a standard definition to guide providers and hospitals in designing and meeting the patient electronic access goal.

We applaud the measure to allow providers to utilize APIs to provide patients with their information. This will give patients more control over their information, break down information silos, and provide additional flexibility for both patients and providers in how the information is used and shared. Because of this, AHIMA believes APIs should be required rather than optional for providers, but that providers should be allowed to decide whether or not to also provide View, Download, Transmit (VDT) functionality based on their knowledge of their patients' existing adoption of VDT and their ability to continue to support VDT functionality. This is Alternate B in the proposed rule. In addition, we strongly agree that it is not appropriate for EPs and hospitals to charge patients a fee for accessing their information using an API. Charging patients for accessing their information in this way is counterproductive and makes it more difficult for providers and hospitals to meet the patient engagement measures whether they are using APIs or VDT technology.

While APIs provide greater flexibility and control of health information, an additional important consideration is privacy and security. It will be necessary to educate providers and hospitals about the privacy and security implications of APIs so that they in turn can educate patients and families on the risks and benefits of sharing PHI with third parties through the use of an API. This requirement for education on sharing information with third parties should be integrated into the measure that allows for APIs.

The measure also requires that information be accessible by patients within 24 hours of its availability to the EP or EH. While we support timely access by patients to their information, we request and recommend a clarification of the term "available." Information and data in the EHR is often "available" to providers but held in a pending or preliminary status, awaiting review and authentication by the provider. There should be clarification that "available" means after this review and authentication process by the provider has taken place. Additionally, providers do not want their patients to see adverse results and findings in their record before a crucial conversation has taken place to inform the patient and their caregivers. Breaching the delicate patient/provider relationship should not be the byproduct of meeting this requirement.

Objective 6: Coordination of Care through Patient Engagement

In general, AHIMA strongly supports the idea of coordination of care through patient engagement. However, we note that these are different concepts that are difficult to integrate through the measures and that may impact the effectiveness as well as the ability of provider to meet the measures. We agree with the observation of the HITPC Consumer Work Group that sending secure messages or receiving data from non-clinical providers does not necessarily imply patient engagement. We also agree with their recommendation that thresholds for these measures be lowered and that CMS should consider moving the measure related to non-provider requested health data to objective—Health Information Exchange.

We support the ability of patients to share all types of data with their providers, as it gives a more complete picture of their health status. However, a distinction should be made between provider-requested patient-generated health data (PGHD) and that which is non-provider-requested. There are few, if any, standards for the latter and it will be necessary to develop policies and standards for provider review and authentication before incorporating non-provider requested data and information as part of a provider's legal record or record of care. We note that there would be little point in incorporating this data and information into a patient's record without requiring provider review, and this could lead to clinical integrity and potential quality and safety issues if a patient was a poor historian or was confused regarding critical clinical facts regarding their past medical history and their recall of their present illness, medications, etc.

For these reasons, we agree that it would be desirable to divide the PGHD measure into two distinct measures. The first measure would include data generated through patient self- reporting and monitoring, as directed by the provider (this would still require review prior to incorporation into the medical record). The second measure would include all other data from a non-clinical setting.

Additionally, we believe that CMS should consider providing guidance on incorporating non-provider requested PGHD into EHRs in order to support EPs, EHs and CAHs in achieving this measure.

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[1] *US experience with doctors and patients sharing clinical notes; BMJ 2015; 350 doi: http://dx.doi.org/10.1136/bmj.g7785 (Published 10 February 2015)*

We also note that the source or provenance of the data and information from non-clinical settings is important in assuring context and validity and should therefore be a requirement before incorporating such non-provider PGHD into a provider's EHR.

We agree that these proposed measures should have a denominator limited to patients with whom the provider has multiple encounters, such as unique patients seen by the provider two or more times during the EHR reporting period. These measures should also not be applicable for eligible hospitals and CAHs.

Objective 7—Health Information Exchange

AHIMA supports the objectives and measures proposed for health information exchange, again with the cautions that the threshold rates for the measures should be reasonable and based on data and experience from Stage 2.

Per the requirement in measure 3 to reconcile problem lists, we note that due to lack of standardization around how problem list data is collected and used by various providers, it may be difficult, and sometimes impossible, for a receiving provider to validate the information on a problem list with the patient. While reconciliation of the problem list is important for quality care, there should first be standards or guidance for reconciling the information before including this in the measure. Reconciliation is essential and much more feasible for medications and medication allergies and should be included in the measure.

The NPRM seeks comment on whether providers who create a summary of care record using CEHRT for purposes of Measure 1 should be permitted to send the created summary of care record either-- (1) through any electronic means; or (2) in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network and whether providers who are receiving a summary of care record using CEHRT for the purposes of Measure 2 should have a similar requirement for the transport of summary of care documents requested from a transitioning provider. It further requests comment on how a governance mechanism established by ONC at a later date could be incorporated into the EHR Incentive Programs for purposes of encouraging interoperable exchange that benefits patients and providers, including how the governance mechanism should be captured in the numerator, denominator, and thresholds for the measures of this health information exchange objective.

AHIMA believes it is essential to have such a governance mechanism for increasing and supporting health information exchange and has long advocated for data standards, especially those for accurately identifying patients, addressing privacy and cyber security, and providing trust agreements; however, no such governance mechanism currently exists, and we respectfully suggest that it is therefore not possible or productive to speculate on how to tie the health information exchange measures to governance until such mechanisms are established. We encourage ONC and CMS to work in a public-private partnership to develop an effective governance mechanism that will support not only the health information exchange objective for meaningful use, but ultimately improve care quality and safety.

Objective 8—Public Health Reporting

AHIMA agrees with the proposal to extend the public health measures into new areas such as case reporting and clinical data registries. We applaud CMS's attempt to broaden the Public Health reporting measures so they apply to a larger group of providers. We also support the flexibility afforded providers relative to "active engagement" in advancing public health reporting which recognizes that public health agencies (PHA) and clinical data registries are in different stages of readiness and development to exchange data with providers. However, we are concerned that the proposed rules potentially create an undue burden on EPs whose states are not mature in their capacity to accept electronic reporting and that participation in clinical data registries will add additional costs for each EP.

The proposed centralized repository where a PHA could post readiness updates regarding their ability to accept electronic data using specifications for the public health objectives will be necessary to help providers with public health reporting measures. CMS should also maintain a continuously updated repository with the names and contact information of specific clinical data registries that are capable of receiving electronic data. We do want to encourage reporting to clinical data registries. Such registry reporting will provide rich data for use in developing evidence-based protocols. What we are not sure about is if there is a clinical data registry appropriate to every clinical specialty. Therefore, it could be difficult for specialists to find three applicable registries for reporting purposes. If not, we suggest that CMS consider counting exclusions in states where electronic reporting is simply not possible. If it is indeed possible for every EP to find a clinical registry appropriate for their specialty, CMS could require EPs to report to one clinical data registry while still accepting exclusions from Public Health reporting. Finally, we would also recommend that EPs be given credit for meeting the measure if a larger health system in which they are working reports to a registry, e.g. cancer, trauma, etc. This would minimize the cost to EPs and makes more sense for specialists.

AHIMA appreciates the opportunity to comment on this NPRM for Meaningful Use Stage 3 and thanks you for consideration of our comments. We look forward to working with CMS to further enhance the implementation strategies of Meaningful Use Stage 3. Should CMS have questions about these comments, please contact me at Lynne.thomasgordon@ahima.org or (312) 233-1165.

Sincerely,

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