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May 7, 2012

Ms. Marilyn Tavenner
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2 (CMS-0044-P)

Dear Acting Administrator Tavenner:

AARP is pleased to offer comments on the Stage 2 criteria that eligible professionals (EPs), eligible hospitals and critical access hospitals (CAH) must meet to qualify for Medicare and Medicaid electronic health record incentive payments. The Centers for Medicare and Medicaid (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have made important strides since the first stage of Meaningful Use (MU). The MU program has established a roadmap for efficient and effective use and sharing of information. It has raised awareness in the provider community of the imperative to share information and the premise that public policies must undergird and drive technological innovation, not vice versa. We believe that strategically designed, incremental improvements can ultimately achieve the health care system that consumers must have—one that offers adequate coverage, evidence-based, high-quality, affordable care that is delivered in a person-centered way, and is enabled by the meaningful use of health information technology (HIT). Therefore, AARP continues to support a phased approach to allow providers and institutions to achieve the goals of MU.

General comments on proposed rule

One-year delay of stage 2 – We agree with the recommendation of the HIT Policy Committee to make all newly proposed objectives core, but we support the need to allow vendors, practitioners, and hospitals a longer timeframe to implement new technologies and modify workflows. In return for the extra time, we expect to see substantial progress on these fronts and anticipate the stage 2 objectives will become core by stage 3. The delay should afford the industry (vendors) additional time to make progress in developing Certified EHR Technology and to meet stage 2 requirements set at a level that recognizes the additional year they have been given to meet the standards.

Strengthening and improving stage 2 requirements- AARP commends CMS and ONC ("the agencies") for continuing to raise the MU bar and to advance health information exchange. We support the stated goals to: reinforce the National Quality Aims and Priorities; encourage continuous quality improvement at the point of care; and encourage information exchange in the most structured format possible.

We also support the transition of "menu" criteria in stage 1 to "core" items in stage 2 and are pleased that EPs will not be able to "count" qualified exclusions as a way to reduce the number of required menu objectives they or an eligible hospital must meet. However, we note with regret the agencies' decision to hold the line on the requirement pertaining to advance directives, which we discuss further below.

Standardized denominators- Harmonized specifications will reduce collection and reporting efforts and permit consistent comparisons. AARP supports the intent of harmonizing denominators as a practical approach to ensuring that data collection and reporting can occur efficiently as part of clinical work flow.

Health information exchange- We agree with the decision to eliminate the stage 1 requirement to simply test the capability of clinical information exchange. The exchange "test" was not a meaningful criterion, particularly because it was not required to be successful, nor did it require that actual patient information be exchanged in a real world situation. Instead, CMS should implement a substitute requirement to electronically transmit a summary of care for an actual patient who is either being discharged or referred to another provider. This is consistent with the goal for stage 2 of electronic exchange of information and is a reasonable expectation for meaningful users.

Alignment with other programs- We support efforts to align the requirements with other CMS initiatives and address this in more detail below in the discussion on quality measurement.

Matching patients to their health information- As we move to more robust exchange of data among providers and with patients, achieving high levels of accuracy in matching patients to their health information will be critical to patient safety and for effective care delivery. The proposed rule does not address any of the Policy Committee's recommendations with respect to achieving greater matching accuracy; instead, the sole mention of the topic is with respect to whether certified EHRs should be required to demonstrate the capability to automatically match patient information received from another source with information already in the record. As noted by the Policy Committee, achieving better accuracy in matching will require a combined policy and technical strategy - it cannot be solved solely by technical capabilities. We urge the agencies to develop a combined strategy to address patient matching prior to the beginning of Stage 2 in 2014.

Stage 2 MU Objectives: Core and Menu Set

Improving quality, safety, efficiency, and reducing health disparities

Use of Computerized provider order entry (CPOE) for medication, laboratory, and radiology orders- CPOE is an important means of improving quality and safety at the point of ordering the script or test. It supports decision support at the point of care and can help reduce communication errors, including those arising from illegible handwriting. The addition of laboratory and radiology orders enhances the use of the technology as does the proposal to require the CPOE function to be used when the first record of the order is made. We recommend that the requirement should pertain only to licensed professionals who are legally permitted to enter items in the medical record. Finally, adding laboratory and radiology orders to the MU objective for CPOE supports other activities, such as quality measurement and reporting.

Clinical decision support- We support the modification of the stage 1 objective that would permit EPs and eligible hospitals to select the clinical decision support interventions that best suit their practices and patient populations so long as the support intervention is related to at least 5 of the clinical quality measures. This modification will retain the intended focus of decision support on high-priority health conditions while ensuring that the support intervention is directly relevant to EPs, including specialists, and eligible hospitals. However, to ensure that clinical decision support is used to improve care, it is necessary for CMS to take steps to ensure that providers use this functionality to address high-priority health conditions, such as variation in high cost services or services that are frequently overused, rather than less significant areas of clinical practice.

Generating and transmitting permissible prescriptions and comparing such prescriptions to at least one formulary- While we agree with the proposal to increase the proportion of permissible prescriptions that would have to be transmitted electronically, we are puzzled by the associated requirement that the EP must compare prescriptions to just a single formulary, as opposed to one that applies to a specific person. In our view the minimal nature of this expectation misses an important opportunity to provide the prescribing clinician with information that (s)he could use to promote the use of generics or less costly drugs to his patient, thereby helping to make prescription drugs more affordable. AARP encourages CMS to at least require the EP to be able to check on a specific patient's formulary for Stage 2 and to expand the requirement to include most, if not all formularies, by stage 3.

Record demographic and disability data: We strongly support the proposed EP and eligible hospital/CAH objectives for recording preferred language, gender, race, ethnicity, date of birth, gender identity, and disability status. We are especially pleased to see the threshold requirement increase from 50 to 80 percent. Information on demographic characteristics is essential for care delivery to be person-centered and focused on individual patient needs. This information is also necessary if clinicians are to be able to recommend appropriate treatments and honor personal preferences. Most important, these data elements are critical to addressing health care disparities among the sub-populations.

Although the proposed regulation would allow the use of other demographic descriptions, the proposed requirement stipulates they would have to be mapped to OMB standards. This approach is not consistent with the CMS' stated objective of harmonizing requirements across its programs. Furthermore, it is important for the electronic record to include more granular information than is possible using the OMB demographic categories. Although the agencies' goal of harmonized standards across programs is worthy, we think the MU stage 2 objective offers the opportunity to establish a more rigorous standard for race and ethnicity data collection that would allow individuals to self-identify for race and ethnicity from a broader range of options. Our suggestion is consistent with a recommendation made by the, the Institute of Medicine (IOM) Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement to Examine Approaches to Standardization in its 2009 report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement.* In this report, the subcommittee recommended collection of more granular ethnicity and language need according to national standards in addition to OMB race and Hispanic ethnicity categories. Therefore, as an alternative to the OMB standards for race and ethnicity, we suggest following a system that would permit more granular identification of race and ethnicity, such as the National Center for Health Statistics' Procedures for Multiple-Race and Hispanic Origin Data: Collection, Coding, Editing, and Transmitting. (http://phinvads.cdc.gov/vads/ViewValueSet.action?id=66D34BBC-617F-DD11-B38D-00188B3 98520#)

Similarly, AARP believes that knowledge of an individual's disability status is critical to effective care planning, selection of treatment interventions, and consideration of patient preferences. AARP recommends the American Community Survey (ACS) from is the National Health Interview Survey (NHIS) as a source for information on disability status. ACS has disability questions that have been widely tested and are in use in multiple government surveys.

However, additional information would enhance the information from the ACS that could be recorded in patient history (such as whether the individual has: a developmental disability (e.g., cerebral palsy, or an intellectual disability): uses assistive technology (e.g., mobility devices, communication devices to promote independence in activities of daily living); difficulty learning or a learning disability; and difficulty communicating, (e.g., the person is nonverbal, communicates through a sign language interpreter, or other communication issues.) Ideally, information should come from self-report from the person with the disability, or if the person with the disability is unable to self-report, from the caregiver. This information should be included as demographic data but also made available for other uses that will allow determination of how care is delivered at the individual patient as well as population level. We support the proposed numerator specification as "the number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data." It is very important to record all the relevant elements, unless the individual declines to provide it, in which case, the declination can be recorded in the certified EHR technology.

Finally, we strongly encourage CMS to identify a means in MU of ensuring that providers actually use the demographic data to stratify clinical quality measures and patient lists. CMS should require these data be used to improve care for all populations and to reduce health disparities. We specifically support those provisions in the proposed rule that would enable EPs and eligible hospitals to so, such as generating reports by condition and stratification of quality measures by race, ethnicity, and other patient characteristics associated with disparate care. The ability to generate reports about a patient population is a key system capability necessary to enable providers to manage information and to address the needs of the population of patients for whom they are responsible. We note the stage 1 objective and measures do not dictate the specific report to be generated. However, to further the value of this objective by making it useful in identifying and addressing disparities, the agencies should require that EPs and hospitals demonstrate that they stratify their populations according to race, ethnicity, or gender.

The MU program provides a unique opportunity to reinforce the federal civil rights laws, and AARP urges the agencies to take full advantage of this through the promulgation and enforcement of pertinent regulations. We urge a clear statement in the final rule that EHR incentive payments constitute federal financial assistance and thus all recipients are obligated to comply with federal laws including Title VI of the Civil Rights Act of 1964 (Title VI), § 504 of the Rehabilitation Act (§ 504), the Americans with Disabilities Act (ADA), and § 1557 of the Affordable Care Act (ACA § 1557).

The agencies should require EHR incentive payment recipients to comply with the Department of Health and Human Services' (HHS's) "Limited English Proficiency (LEP) Guidance" and work with the Office of Civil Rights (OCR) to determine the most effective ways to educate providers and institutions that receive EHR incentive payments and assist them in complying with these laws. They should also require EHR incentive payment recipients to provide sign language interpreters or other assistance to comply with § 504. Finally, we urge the agencies to require discharge instructions, EHR-enabled patient-specific educational materials to be provided in the common primary languages, in compliance with Title VI, ACA § 1557, and HHS LEP Guidance.

Use clinically relevant patient information to send reminders for preventive or follow-up care. Reminders are an important means of assuring that patients receive necessary care and help individuals to engage more actively by alerting them to up-coming visits. We agree with the decision to extend this requirement from just the ends of the age spectrum (>65 and < 5 years of age) to all active patients. Since individuals will vary concerning their preferred mode of communication, we urge that the requirements address the expectation that these preferences will be recorded in the EHR. However, it is not clear to us why the proposed rule lowers the proportion of unique patients a provider must reach with reminders from 20 percent in stage 1 to 10 percent in stage 2. We recommend CMS clarify the basis for this change.

Make imaging results and information available through EHR technology- We agree that this new menu requirement, preferably met through the electronic transmission of the images and scans, should improve safety and help to conserve resources by avoiding the need for duplicative diagnostic scans and images, and supporting patient access to such information as well.

Record patient family history as structured data- AARP strongly supports the requirement for meaningful users to employ technology that can capture family history as structured data. Family history offers an essential set of data elements that can inform clinical and patient decisions, particularly for those with chronic conditions. Moreover, there is no more often cited annoyance by patients than having to repeat family history at each medical encounter or to each practitioner. The ability to have family history recorded and the opportunity for patients to easily update it will facilitate information exchange and patient/family engagement. We recognize meeting this new menu objective may yield inconsistent approaches, but we believe the agencies can be more specific with respect to standards in stage 3.

Engage patients and families in their health care

 "View, download and transmit" - We strongly support the new core requirement that providers offer more than 50 percent of their patients timely electronic/online access to their health information (as opposed to simply providing them with an electronic copy) within 4 business days, and for eligible hospitals to allow such patients to view online, download and transmit information about a hospital discharge within 36 hours of discharge. These requirements will enable consumers to become more proactive in their care by giving them ready access to this information and will facilitate and enable information sharing between and among their providers of care.

Further, we also strongly support the proposal that 10 percent of all patients view, download, or transmit to a third party their health information during the reporting period. The 10 percent threshold is a modest expectation that incents providers to engage their patients by motivating and encouraging them to use and share relevant personal information in their care. We can conceive of multiple ways providers might meet this objective, such as by demonstrating to patients how to access and use the information that is available for download and sharing. In fact, the very process of demonstrating how to access the information is a form of initial engagement that would give a provider credit for meeting this objective. In the final analysis, providers must accept responsibility for ensuring that their patients use information to improve health outcomes through motivation, communication, and demonstration of the utility of the information. Forging trusting relationships with patients and helping them to engage in active partnerships is part of the cultural transformation that is essential to a person-focused system. We believe HIT can help to advance this transformation.

Helpful information that people can use to manage their care when they are not directly interacting with their care team (e.g., after an encounter) is a critical support that everyone needs, regardless of their condition or health status. Access to information electronically greatly enhances opportunities to engage in one's care, by sharing information with providers, caregivers, or other members of the patient's team, and to help them to better coordinate and manage their care needs. The combined actions of patients armed with timely, relevant information to help them effectively manage their condition and a care team that appropriately shares relevant information to coordinate and manage their patient's needs can lead to better health outcomes. In the case of specialists, we support flexibility in meeting the criterion to electronically transmit information by allowing them to convey information to a patient's primary care physician, who, in turn, can give patients access to the information online or through a patient portal. However, we urge the agencies to consider mechanisms to avoid a proliferation of patient portals that would confuse patients and needlessly complicate data/information sharing by clinicians.

With respect to the view, download and transmit criterion, EPs and eligible hospitals will be required (by the HIPAA Security Rule) to provide this service to patients with technical, administrative and physical safeguards. The proposed rule provides little detail on what constitutes "good" security for the view, download and transmit functionality. Therefore, the Office for Civil Rights should issue further guidance to providers in time for stage 2 implementation to support this objective.

Clinical summaries for patients- We support the criterion that EPs provide a clinical summary of an office visit without charge, within 24-hours of the visit to 50 percent of their patients. This is a reasonable timeframe (a welcome and appropriate improvement over the stage 1 3-day requirement) and provides necessary information to support patient engagement by reinforcing actions discussed during the visit. In addition to the items listed in the proposed rule, we recommend that the clinical summary also should include the reason for the visit or hospital admission, the prescriber's name and date or prescribed medicines and the timeline for care plans, and patient preferences.

Patient-specific education resources- Patient-specific resources can help people better manage their care and adhere to care plans, and many resources can be queried using certified EHR technology. Having specific recommendations from their clinicians will better ensure that patients rely on materials their clinicians agree are suitable for their circumstances. We recognize it will continue to be challenging to find electronic materials that address the full range of health literacy skills, but we believe this objective will also incent meaningful users to pay more attention to the health literacy skills of their patients and encourage them to be mindful of their patients' skill levels when they offer educational advice and materials. Here again, we believe that this objective supports practice transformation and therefore, we urge the agencies to raise the threshold for this objective from more than 10 percent of all office visits or admissions to 25 percent to support and advance this important objective.

Secure messaging - AARP is pleased with the inclusion of this requirement as a core objective in stage 2. The ability of patients to communicate directly with their clinicians is another key function to help patients engage in their own health care. In addition, secure messaging affords the opportunity to avoid needless face-to-face encounters and harnesses the promise of technology to support emerging models of care that offer greater flexibility, convenience, and conservation of resources. In the final analysis, access to secure messaging that would allow EPs and patients to communicate will do more to help consumers appreciate and understand the value of health information technology than any public awareness campaign or educational initiative ever could.

Improve care coordination

Medication reconciliation- Medication reconciliation is one of the most important activities clinicians can pursue to assure that care is coordinated and harm avoided. It is a process that is particularly relevant to patients who take multiple medications, for those transitioning from one care setting to another, and those under the care of more than one physician. Raising the threshold for EPs, eligible hospitals or CAH to perform medication reconciliation for more than 65 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital or CAHs may be a significant hurdle for some. However, given the criticality of this function, we believe it is appropriately aggressive with potentially high benefit for improved patient care. Further, this requirement will inure to the advantage of patients in post-acute facilities—patients highly likely to benefit from medication reconciliation.

*Summary care record -*The proposed objective of requiring EPs, eligible hospital or CAH who transition their patients to another setting of care or provider or who refer the patient to another provider must provide a summary care record for each transition raises the stage 1 threshold of 50 percent of all referrals/transfers to 65 percent. Ten percent of these summaries must be sent electronically to a provider using a different EHR vendor to demonstrate the ability to exchange information. AARP suggests the threshold be raised even higher to 80 percent. The exchange of key clinical information can be achieved efficiently through the use of technology, thereby reducing the burden on the referring providers of the need to provide relevant summary information to the receiving provider. Certain basic information needs must accompany a transition to ensure a safe handoff, without which patient safety is potentially jeopardized. To the proposed list (patient name, referring or transition provider and contact, procedures, relevant past diagnoses, laboratory test results, vital signs, smoking status, demographic information, goals and instructions, care team members, discharge instructions (for eligible hospitals and CAHs), up-to date problem list, active medication allergy list, active medication list,) we suggest adding the date and reason for the admission, if applicable, and the name of the prescribing clinician and date of the prescription. All of this information is important for other aspects of care; therefore, it should be readily accessible in the EHR so that it can be accessed and updated at times other than just transitions.

Improve population and public health

AARP recognizes the tremendous opportunity to advance the wide range of public health needs, including population health, and surveillance activities, through the submission of vital public health data electronically from EHRs (e.g., successful ongoing submission of immunization data to an immunization registry or immunization information system, and capability to submit electronic clinical surveillance data to public health agencies, as permitted by application law and practice, as is proposed for stage 2.) For example, requiring ongoing submission of electronic data to registries would be a significant step forward in encouraging exchange of information in support of public health initiatives. Similarly, the new menu objectives requiring ongoing submission to cancer and specialty registries is an important step in promoting exchange of information, enabling more robust quality measurement, and improving quality of care for specific conditions and populations. (This will also make MU more relevant to specialists.) We therefore strongly support this approach.

Ensure adequate privacy and security protections for personal health information

Risk assessment- AARP supports the stage 2 proposal to continue requiring EPs and eligible hospitals to perform a security risk assessment and address deficiencies identified in the assessment with the addition of a new requirement for providers and hospitals to attest to having addressed encryption of data at rest as part of this risk assessment. This is consistent with the HIPAA Security Rules and will not add additional burden to the risk assessment process.

We want to note an important opportunity for CMS to use MU payments as a vehicle to signal to the provider community the imperative to be in good standing with respect to state and federal privacy laws. AARP recommends that CMS should deny MU payments to any EP or hospital found to be in willful violation of the HIPAA privacy and security requirements and fined for such violations.

Advance directives- AARP was disappointed with the decision to retain the requirement for advance directives in the menu set rather than advance it to the core set, out of concern that there are potential conflicts between storing advance directives in EHRs and existing state laws. We see a pressing need to ensure that patient preferences are honored throughout the continuum of care, but especially for older persons and people with advanced illness who may be near the end-of-life. Too often, individuals' preferences are not recognized, either because they are not elicited by clinicians or because they are ignored. A necessary first step is to ensure that advance directives are recorded in hospital and physician records. We also regret the agencies' decision not to include EPs in the requirement to record whether a patient age 65 or older has an advance directive. Furthermore, we question the given rationale, that EPs "would not record this information under current standards of practice." In fact, the hallmark of a person-focused health care system that rests on the "three aims" identified in the National Strategy for Quality Improvement in Health Care is honoring and respecting patients' preferences. We are

unable to identify any preference more worthy of consideration by a practitioner or institution than those expressed by individuals in their advance directives.

Accordingly, AARP strongly urges the reconsideration and reversal of the decisions: (1) not to require eligible hospitals to record advance directives as a core standard; (2) not to require EPs to record advance directives as a menu standard; and (3) to restrict the advance directive requirement to patients ages 65 and older.

Finally, we encourage CMS to consider ways to incorporate state-specific advance directive types of forms in EHR vendor products and to consider use of the POLST (Physician's Order for Life Sustaining Treatment") in Stage 3 as a potential alternative to an advance directive. POLST is based on the premise that effective communication between the patient or legally designated decision-maker and health care professionals ensures that decisions are sound and based on the patient's understanding of his/her medical condition, her prognosis, the benefits and burdens of the life-sustaining treatment and her personal goals for care. POLST instruments are state-specific to accommodate each state's particular requirements and are specifically intended to be included in the patient record. Information on the POLST form becomes a physician's order that is signed by both the physician and the individual, making this a potentially effective means of integrating this type of information in formats already standardized and familiar to EHR users.

Reporting on Clinical Quality Measures (CQM) Using Certified EHR Technology

The use of health information technology should enable and facilitate improved patient health outcomes and assessment to determine whether these improved outcomes have been achieved. HIT can make it easier to measure provider performance using data that are accessible in the EHR. In addition, the EHR is a rich source of clinical data that are not easily obtained from other sources. AARP strongly urges the agencies to take the necessary steps in stage 2 MU requirements to prepare the provider and vendor communities for the previously announced focus on improved outcomes in stage 3. This will entail the development of functionalities in certified EHRs that: can link clinical decision support and quality metrics; have the capability to assess timeliness of care delivery; have the ability to factor multiple data sources into a single quality metric; and assess care longitudinally over time. In addition, it will be important to ensure that the standards for certified EHRs include the ability to collect patient-reported/generated data that can be captured and converted into valid and reliable quality measures.

We cannot understate the importance of taking advantage of the lead time afforded in stage 2 to signal to vendors and providers the agencies' intention to significantly intensify their demand for higher value measures in stage 3. If the goal of achieving the three aims is to be met by stage 3, it is essential to establish expectations and a plan of action right away.

Urgent need to strengthen the rigor of the quality measure set. We note many gaps in the proposed list of stage 2 quality measures. Sadly, these gaps mean that all six proposed domains of measurement (patient and family engagement, patient safety, care coordination, population/public health, efficient use of health care resources, and clinical effectiveness) cannot be addressed in stage 2. The proposed list is dominated by process measures for which evidence of a clear link to an outcome is often lacking. Very few outcome measures are proposed. In addition, there are "check the box" measures—which are neither meaningful for public reporting nor appropriate for payment-based programs. And, there is no requirement for a patient experience measure. (We recommend that certified EHRs should have a field to record that an individual's experience was *assessed.)* There are too many "legacy" measures among the proposed measures that are low-value and that have been retained from very early measurement initiatives despite the fact that there are now more robust measures that could replace them; moreover, performance on several of these older measures has topped out, and CMS has "retired" them. Finally, there are measures that do not harness the potential of the EHR and do not tap this rich and unique source of patient-specific clinical information.

As the final subset of measures for stage 2 is identified, we urge CMS to select measures that are most likely to yield the highest value for the data collection and reporting effort. In addition, we also strongly urge CMS to invest in the development of measures that will permit assessment of performance on the basis of patient outcomes, functional status, quality of life and the dimensions of care that are important and salient to consumers. The recommendations of the Tiger Team of the HIT Policy Committee concerning measure concepts offers the opportunity to conduct a crosswalk between certification requirements and the measure concepts and to identify gap areas in the measurement areas that require corresponding functionalities in certified EHRs. This crosswalk along with the National Priorities and Goals could guide the agencies' measure development agenda by identifying the data elements and the technical specifications needed for future performance assessment initiatives.

Criteria to select the initial list of proposed clinical quality measures— As noted above, AARP generally supports alignment among federal and private programs, such as the Physician Quality Reporting System, those created by the National Committee for Quality Assurance for medical home certification, the Children's Health Insurance Program, and the reporting programs of the Hospital Inpatient Quality Reporting Initiative, and that of The Joint Commission. Alignment reinforces objectives to reduce data collection and reporting burden and helps to conserve scarce resources. Avoiding duplication and redundant efforts and increasing consistency in public reporting and payment programs underscore the importance of ensuring that only high-value performance measures are incorporated into all CMS initiatives. Clearly, alignment for its own sake is pointless. For example, we do not support the proposed rule's approach that would give automatic credit in MU for quality reporting under PQRS, unless the PQRS measure is determined to be of 'high-value' (see below).

AARP agrees with efforts to assure that the quality measures comport with the National Quality Strategy and Priorities (make care safer, promote effective communication and care coordination, promote effective prevention and treatment practices, work with communities to advance healthy living, and make care more affordable). The purpose of national priorities is to marshal resources toward agreed upon areas of work and optimizes the work of all stakeholders to improve care. We strongly support the decision to use measures in stage 2 that address known gaps in care, such as where performance is known to be low or highly variable.

Although we are not commenting on specific CQMs in this letter, we urge the inclusion of measures that are especially salient and clinically important for older consumers. We do support the criterion to have measures applicable to all CMS programs, including those where measures are applicable to pediatric care and that assess whether treatment recommendations are followed. We oppose the inclusion of the following types of measures: those that are not "high-value" measures—e.g., those that measure basic competency; "good" measures that do not advance the effective use of the technology (and therefore should not be included in MU); and "good" measures that assess performance that is consistently "topped out" and therefore there is no variation among providers.

Reporting options-For reporting beginning in 2014, we recommend proposed reporting option 1b that requires EPs to report 11 core CQMs listed in Table 6 of the proposed rule plus 1 menu item from Table 8. For primary care and group reporting, we recommend option 1b because this set of measures could begin to assess team-based care. We recommend that CMS adopt option 1a for specialists to make MU as relevant to their practice as possible. We do not support Option 2, because the PQRS measures do not generally demonstrate the meaningful use of health IT.

Conclusion

AARP appreciates the opportunity to offer these observations and recommendations. We fully recognize the enormous challenges that remain in order to achieve a system in which information is fully interoperable and in which the motivation to share information that is secure and protected is fully realized and understood by providers and patients alike. The end goal is not the adoption of technology per se, but it is the attainment of a system that offers everyone, high quality, efficient, and affordable health care services. It continues to be critically important that the vendor community keep pace with the need for patient-reported/generated information by incorporating functionalities that respond to the policy direction set by the agencies and the demand from the clinical community for technology that enables and facilities compliance with the evolving meaningful use requirements. A viable market for decision support and functionality that undergirds the policy direction for patient-reported outcomes and shared decision making is essential. AARP is pleased that the process to shape the meaningful use program has been open, inclusive and transparent and we look forward to working with the agencies to ensure that the promise HIT brings to health care will be fully realized through the MU program.

AARP appreciates this opportunity to comment on this rule. If you have any questions, please feel free to contact Leah Cohen Hirsch of our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs