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Glenn M. Hackbarth, J.D., Chairman
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Mark E. Miller, Ph.D., Executive Director

March 12, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Ms. Frizzera:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the proposed rule CMS-0033-P (published January 13, 2010 at 75 FR 1844). This rule would implement the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) to provide incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare (and Medicaid) that adopt and meaningfully use certified electronic health record (EHR) technology. We appreciate your staff's thoughtful and thorough work on this proposed rule, particularly considering the agency's competing demands and limited resources.

For several years, MedPAC has supported the use of Medicare payment incentives to increase providers' adoption and use of EHRs and other types of health information technology (HIT) to improve the quality of care for Medicare beneficiaries and increase the efficiency of health care service delivery. In our March 2005 Report to the Congress, we recommended that Medicare pay-for-performance programs should include measures of quality for activities that rely on the use of HIT, such as tracking care over time for patients with certain chronic conditions, using clinical decision support tools during patient encounters, and securely transmitting patient care information between providers across care settings.

In November 2009, the Commission unanimously approved a set of recommendations that would improve Medicare's ability to compare the quality of care between Medicare Advantage (MA) and traditional fee-for-service Medicare, and among MA plans. The first of these recommendations is that the Secretary should define EHR "meaningful use" criteria such that all qualifying EHRs can collect and report the data needed to compute a comprehensive set of process and outcome measures, and that qualifying EHRs should have the capacity to include and report patient demographic data, such as race, ethnicity, and language preference.

We continue to strongly support the use of HIT as a tool for providers to improve the quality and reduce the cost of care for Medicare beneficiaries. Effective EHRs should increase the quality of

care; reduce unnecessary service use and costs, or both. Medicare should subsidize only those EHRs that achieve these goals.

Our specific comments in this letter focus on three areas of the proposed rule:

- The proposed requirement that eligible hospitals and eligible professionals must meet all of the Stage 1 meaningful use criteria to qualify for incentive payments
- The proposal not to include the HIT Policy Committee's recommended meaningful use objective to provide access to patient-specific education resources upon request
- The proposal to consider applying the hospital meaningful use criteria to hospital outpatient services in Stage 2 of the incentive program phase-in schedule

Proposed requirement that hospitals and eligible professionals must meet all of the Stage 1 meaningful use criteria to qualify for incentive payments

CMS proposes that eligible hospitals and eligible professionals would have to meet all of the Stage 1 meaningful use criteria in the first applicable reporting period in order to receive an incentive payment. CMS is proposing 25 criteria for eligible professionals and 23 criteria for hospitals (see Table 1 at the end of this letter).

Overall, the scope and timing of CMS's proposed Stage 1 meaningful use criteria are consistent with MedPAC's recommendations for increasing providers' use of EHRs to improve quality and reduce health care costs. We note that the proposed Stage 1 criteria closely follow the final recommendations on defining meaningful use that were adopted by the HHS HIT Policy Committee in July 2009. The Commission strongly supported the initial draft of that committee's recommendations and provided comments on instances where specific measures or objectives in the HIT Policy Committee's draft definitions were consistent with the Commission's stated positions or suggestions (see attached letter dated June 26, 2009 from MedPAC to Dr. David Blumenthal, which also is available at http://www.medpac.gov/documents/06262009_HITPolicy_COMMENTjr.pdf).

Thus, we strongly support CMS's proposal to require that a hospital or eligible professional meet all of the Stage 1 meaningful use criteria for the applicable reporting period in order to qualify for an incentive payment for that period. If adopted in the final rule, this proposal, together with the proposed definition of the EHR reporting period for the initial payment year and the incentive implementation schedules, in effect would require eligible professionals to meet all 25 applicable Stage 1 criteria by October 1, 2012 and eligible hospitals to meet all 23 applicable Stage 1 criteria by July 1, 2013 to receive the maximum amount of total incentive payments available through the program.

To provide a degree of flexibility for hospitals and eligible professionals to meet this requirement, CMS proposes to allow both types of providers to qualify for the incentive payments if they meet the Stage 1 criteria for only 90 continuous days of their initial EHR reporting period. That is, an

eligible professional could receive the maximum incentive amount available over the span of the program—\$44,000 over 5 years if the first successful reporting period is in 2011 or 2012—if they begin to meet the criteria for the last 90 days of either calendar year. Hospitals could receive the maximum 4-year total of their available incentive payments if they meet the Stage 1 criteria for the last 90 days of FY 2013. This proposal seems to be a reasonable approach to allow hospitals and eligible professionals sufficient time to implement an EHR system that meets all of the proposed Stage 1 criteria.

Proposal not to include the HIT Policy Committee’s recommended meaningful use objective to provide access to patient-specific education resources upon request

CMS proposes not to include as a Stage 1 meaningful use objective a requirement that a hospital or eligible professional use the EHR to provide patients with access to patient-specific education resources upon request. This was one of the objectives in the HIT Policy Committee’s recommendations that MedPAC supported in its June 26, 2009 letter to HHS. Our research indicates that IT helps to facilitate the use of shared decision-making. Providers use IT to track patients who could benefit from specific decision aids, allow physicians to order aids by clicking a button on the patient’s medical record, disseminate aids, and at times, track patient survey responses.

In short, an IT infrastructure may be critical to the success of patient shared decision-making programs. Incorporating this objective into the Stage 1 meaningful use criteria would facilitate the infrastructure for broader implementation of shared decision-making and measurement of patient access to relevant education resources. We urge CMS to accept the HIT Policy Committee’s recommendation that the Stage 1 meaningful use criteria include the objective to provide access to patient-specific education resources upon request.

Application of hospital meaningful use criteria to hospital outpatient departments

CMS proposes to apply the eligible hospital meaningful use criteria in Stage 1 of the incentive program to the inpatient hospital setting only. In the proposed rule, CMS states that it “may consider applying the criteria more broadly to both the inpatient and outpatient hospital settings” in Stage 2 of the program (75 FR 1852).

We believe it is important for the meaningful use criteria to apply to as many Medicare beneficiaries as possible as soon as possible, regardless of the setting within which they receive care. In light of that principle, and considering the rapid growth in the use and costs of hospital outpatient services in recent years, we suggest CMS should state explicitly in the final rule that the appropriate Stage 1 meaningful use criteria will be applied to EHRs used in the hospital outpatient setting in Stage 2 of the program (i.e., as soon as 2013). The specific objectives and measures that would be appropriately applicable to the hospital outpatient setting could be defined through the future rule-making that CMS already plans to do in advance of the 2013 payment year.

Charlene Frizzera
Acting Administrator
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MedPAC appreciates this opportunity to comment on the proposed rule. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a large initial "G" and "H".

Glenn M. Hackbarth, J.D.
Chairman

GMH/jr/wc

Table 1. CMS Proposed Stage 1 Criteria for EHR Meaningful Use

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Improving quality, safety, efficiency, and reducing health disparities	Provide access to comprehensive patient health data for patient's health care team	1. Use CPOE	1. Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders For eligible hospitals, CPOE is used for 10% of all orders
	Use evidence-based order sets and CPOE	2. Implement drug-drug, drug-allergy, drug-formulary checks	2. Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality
	Apply clinical decision support at the point of care	3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®	3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data
	Generate lists of patients who need care and use them to reach out to patients	4. Generate and transmit permissible prescriptions electronically (eRx)	Not applicable	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
	Report information for quality improvement and public reporting	5. Maintain active medication list	4. Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
		6. Maintain active medication allergy list	5. Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data
		7. Record demographics <ul style="list-style-type: none"> • preferred language • insurance type • gender • race • ethnicity • date of birth 	6. Record demographics <ul style="list-style-type: none"> • preferred language • insurance type • gender • race • ethnicity • date of birth • date and cause of death in the event of mortality 	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data

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		8. Record and chart changes in vital signs: <ul style="list-style-type: none"> • height • weight • blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2-20 years, including BMI. 	7. Record and chart changes in vital signs: <ul style="list-style-type: none"> • height • weight • blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2-20 years, including BMI. 	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20
		9. Record smoking status for patients 13 years old or older	8. Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have “smoking status” recorded
		10. Incorporate clinical lab-test results into EHR as structured data	9. Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
		11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	10. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with a specific condition.
		12. Report ambulatory quality measures to CMS or the States	11. Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
		13. Send reminders to patients per patient preference for preventive/ follow up care	Not applicable	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over

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		14. Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	12. Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).
		15. Check insurance eligibility electronically from public and private payers	13. Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital
		16. Submit claims electronically to public and private payers.	14. Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital
Engage patients and families in their health care	Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health	17. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	15. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours
		Not applicable	16. Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it
		18. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	Not applicable	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information
		19. Provide clinical summaries for patients for each office visit	Not applicable	Clinical summaries are provided for at least 80% of all office visits
Improve care coordination	Exchange meaningful clinical information among professional	20. Capability to exchange key clinical information (for example, problem list,	17. Capability to exchange key clinical information (for example, discharge summary,	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information

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	health care team	medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	
		21. Perform medication reconciliation at relevant encounters and each transition of care	18. Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
		22. Provide summary care record for each transition of care and referral	19. Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals
Improve population and public health	Communicate with public health agencies	23. Capability to submit electronic data to immunization registries and actual submission where required and accepted	20. Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
		Not applicable	21. Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)
		24. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	22. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)

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<p>Ensure adequate privacy and security protections for personal health information</p>	<p>Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.</p> <p>Provide transparency of data sharing to patient.</p>	<p>25. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</p>	<p>23. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</p>	<p>Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary</p>

Source: 75 FR 1867-1870.