MEDPAC Medicare Payment Advisory Commission

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June 26, 2009

David Blumenthal, M.D., M.P.P.
National Coordinator
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Ave, SW, Suite 729D
Washington, D.C. 20201

Attention: HIT Policy Committee Meaningful Use Comments

Dear Dr. Blumenthal:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the draft recommendations presented by the Meaningful Use Workgroup of the HIT Policy Committee on June 16, 2009 concerning the criteria to define the term "meaningful use" with respect to the Medicare and Medicaid incentives for adoption and use of certified electronic health record (EHR) technology by hospital and physicians (and other eligible professionals) as set forth in the American Recovery and Reinvestment Act (ARRA) of 2009 (Public Law 111-5, Division B, Title IV, Subtitle A).

In its March 2005 Report to the Congress, MedPAC discussed the use of payment incentives to support the adoption and use of health information technology (IT) with the goals of improving the quality of care for Medicare beneficiaries and increasing the efficiency of health care service delivery. MedPAC specifically recommended that, in the case of Medicare initiatives that would financially reward providers on the basis of quality, CMS should include measures of functions that are most effectively performed with the use of IT, such as tracking patients with certain conditions, using clinical decision support tools, and transmitting patient care information across settings. MedPAC continues to strongly support the use of health IT as a tool to improve the quality and reduce the cost of care for Medicare beneficiaries.

We believe that the criteria for ascertaining meaningful use of health IT should be based only on uses of health IT that are proven to increase quality, reduce costs, or both. Further, the criteria should incorporate specific measures of clinical processes and outcomes supported by or enabled with the use of health IT, and not based simply on the presence of IT in a hospital or provider's office or its use for administrative functions such as billing and patient record-keeping. Eventually, the criteria defining meaningful use should support payment policy

reforms that will drive health care delivery system improvements, for example reducing payments to hospitals with significantly high readmission rates and financially rewarding providers that efficiently deliver demonstrably high-quality care.

Overall reaction to recommended meaningful use criteria released June 16, 2009—In general, the Commission supports the recommended direction and ambitious pace of phasing in the objectives and measures of meaningful use presented by the Committee on June 16. The following sections of this letter comment on instances where specific measures or objectives recommended at the June 16 meeting are consistent with the Commission's stated positions or suggestions. Our comments are organized according to the sections of the "Meaningful Use Matrix" included in the documents released by the Committee on June 16.

Improve quality, safety, efficiency, and reduce health disparities—The Commission has recommended that Medicare use quality measures that rely on clinical laboratory test results and prescription drug data. We are encouraged to see meaningful use objectives and measures proposed for 2011 that would support the implementation of these recommendations, for example "Maintain active medication list" and "Incorporate lab-test results into EHR" as objectives, and "Use of high-risk medications in the elderly" and "Percent of lab results incorporated into EHR in coded format" as measures. Access to lab results and prescription drug prescribing data would be more readily available through EHR technology and should be included in the meaningful use criteria from the outset of the Medicare incentive program.

The Commission also has discussed the importance of widespread use of computerized provider order entry (CPOE) systems. Physicians and other health care professionals can use CPOE to check for drug-to-drug interactions and drug allergies when they place pharmacy orders, and to assess consistency of orders with evidence-based care guidelines. We support the proposed inclusion of CPOE in the early stages of meaningful use criteria, with the introduction of more stringent criteria to encourage broader use of CPOE over time.

The Commission also has discussed the value of patient registries and other tools that aggregate clinical data from a provider's entire patient population and enable these data to be analyzed and tracked over time for adherence to evidence-based medicine and health outcomes. The Commission has recommended that providers should be able to generate lists of patients with specific clinical conditions, for example, a registry of patients with diabetes or congestive heart failure that can be used to actively manage their care, or a list of patients who have been prescribed a particular prescription drug that could be used for post-market surveillance of clinical outcomes. The latter function will be increasingly important if and when a pathway is created for the approval and use of follow-on biologics. We support the recommended inclusion of patient registry functions in the meaningful use criteria from the initial year of the Medicare incentive program.

We endorse the inclusion of the criterion labeled "Report 30-day readmission rate" for inpatient hospitals. While CMS is now reporting hospital-level readmission rates for certain conditions calculated from Medicare claims data, there is a long time-lag inherent in claims-based measures. One of the key benefits to providers of an interoperable EHR system is to greatly accelerate the rate at which information about a patient is available to all the providers involved in his or her care. This capability will enable providers to take action in real-time to address operational issues that may be contributing to poor quality performance. The criteria for meaningful use should set an expectation that providers use this capability of faster data capture, retrieval, and analysis to improve quality.

Lastly, we support the recommended inclusion of measures that address both quality and resource use efficiency, such as "Potentially preventable Emergency Department Visits and Hospitalizations" and "Inappropriate use of imaging (e.g. MRI for acute low back pain)." As soon as possible, health IT use should support Medicare's and providers' efforts to avoid providing unnecessary care. The Commission also agrees with the principle set forth in the recommended criteria for 2013 and 2015 that the clinical outcomes measures, efficiency measures, and safety measures included in the meaningful use criteria should evolve over time to remain consistent with clinical developments and new quality and resource use efficiency measures.

Engage patients and families—The Commission supports the Committee's proposal to include measures of patients' access to their clinical information, patient-specific educational resources, and other tools that support shared clinical decision-making. The Commission's research indicates that health IT can be an essential component in making shared decision-making more convenient and accessible for patients and providers.

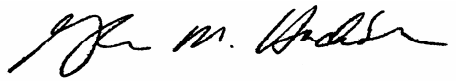
Improve care coordination—Over the last several years, including in our June 2009 Report to the Congress, the Commission has examined and expressed serious concerns about persistent gaps in care coordination for beneficiaries enrolled in traditional fee-for-service (FFS) Medicare. Effective care coordination has the potential to increase quality and reduce costs, and health IT with health information exchange capabilities can enable providers to organize care around an individual as they transition across care settings. Therefore, we support the proposed criteria to measure how care transitions are managed. The proposed criteria would be a solid foundation on which providers can build delivery system reforms and specific interventions to address the gaps in care coordination affecting most Medicare FFS beneficiaries today.

We also note that the Commission has analyzed and made recommendations to provide incentives to providers for improving beneficiaries' care transitions between skilled nursing facilities (SNFs) and inpatient hospital and community settings. While SNFs are not contemplated in the ARRA as a provider type eligible for the Medicare EHR

incentives, we suggest it may be worthwhile to consider how the final set of meaningful use criteria may effectively be applied to them and other similarly-situated provider types as the use of EHR technology becomes the norm in the health care delivery system.

MedPAC appreciates this opportunity to comment on the draft recommendations for the criteria to define the term "meaningful use" of certified EHR technology. If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.