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March 15, 2010

Charlene Frizzera

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-0033-P

Mail Stop C4-26-05

7500 Security Blvd.

Baltimore, MD 21244-1850

Re: Proposed Changes to the Medicaid and Medicare Program: Electronic Health Record Incentive Program (CMS-0033-P)

Dear Ms. Frizzera:

The National Patient Advocate Foundation ("NPAF") would like to thank you for the opportunity to comment on the Notice of Proposed Rule Making ("NPRM") on the Medicare and Medicaid electronic health record incentive programs, published by the Centers for Medicare & Medicaid Services ("CMS") in the *Federal Register* on January 13, 2010.

NPAF is a non-profit organization dedicated to improving access to healthcare services through policy reform. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive counseling and case management services from our companion organization, the Patient Advocate Foundation ("PAF"), which specializes in mediation for access to care, job retention, and relief from debt crisis resulting from a diagnosis of a chronic, debilitating or life-threatening disease. In 2009, PAF received 3,169,037 webpage views providing patients with access to live chats, authored 28 educational publications, and provided consumers with links to hundreds of additional educational websites. PAF initiated the provision of direct services to 55,384 individuals during that time. Over 18 percent of the individuals helped by PAF were Medicare beneficiaries and about almost 77 percent were individuals dealing with a diagnosis of cancer. At the end of February, PAF launched a unique online resource directory for the nation's underinsured (see <http://www.patientadvocate.org/help4u.php>). Paper versions of the new directory are available as well.

We applaud CMS, the Office of the National Coordinator ("ONC") and volunteer members and staff of the HIT Policy and the HIT Standards Committees for their efforts in developing a strong Electronic Health Record ("EHR") framework over the past year. Those who closely followed the work of the American Health Information

Community (“AHIC”), the public-private healthcare information technology policy advisory panel created in 2005 by Secretary Mike Leavitt, believe passage of the HITECH Act was a turning point for vendors and providers because the law directs the development of federal standards that will support the evolution of interoperability and provides for financial incentives designed to spur investment by hospitals and health professionals in EHR systems.

NPAF shares the view of key stakeholder groups such as the American Hospital Association and the Medical Group Management Association – as well as other recognized voices of hospitals and physician practices – that meaningful use of EHRs will increase provider efficiency and effectiveness in ways that benefit patients, their communities and the health professionals that serve them. We agree too with the need to measure meaningful use to ensure achievement. As the voice of patients, NPAF believes the adoption of EHR technology must be coupled with the effective use of the systems. Otherwise the technology will not live up to its promise of reducing errors, improving quality, and addressing the problem of ever-increasing costs. However, because serving the needs of patients must always be paramount, it is critical for the nation’s EHR systems to be built around patient needs.

It is clearly in patients’ interest to have a well-executed, clearly delineated EHR system. The NPRM represents a solid attempt at establishing the necessary hospital and provider-based framework. Although the goals and criteria set forth in the NPRM are, in our view, reasonable, we fear the proposed implementation schedule for the EHR Medicaid and Medicare incentive programs is too aggressive. Simply put, the structure of “meaningful use” outlined in the proposal requires too much, too soon. By doing so, the rule may have the unfortunate effect of discouraging – not encouraging – some hospitals and health professionals from accepting the challenge of moving health records into the electronic age.

Given the extraordinary implications for our health system, providers, and patients, NPAF believes it is more important to ensure that the implementation of EHRs by a broad range of providers goes smoothly and effectively than it is to achieve implementation quickly. The HITECH Act allows the phase in of this critical program to extend through to 2017 – two years beyond the beginning date set for Stage 3 implementation under the NPRM. We suggest considering pushing back the beginning of the program from the planned start date of October 1, 2010 for hospitals and January 1, 2011 for physicians and other eligible providers, moving some of the more technologically complex criteria for meaningful use from Stage 1 into Stage 2 or even Stage 3, adjusting the all-or-nothing approach to measuring meaningful use, at least in the second year of Stage 1, expanding the time frame for each of the implementation stages, or some combination of the aforementioned to better balance the goal of achieving the promise of broad adoption of EHRs with the risk of discouraging less prepared hospitals and professionals from accepting the challenge of moving forward. Even the most technologically savvy hospital, health system or large physician practice

will be challenged to find a certified HIT vendor that can supply systems capable of meeting all of the criteria required for Stage 1 program certification. The unknowns that still surround state Medicaid guidance and potential for state issuance of their own set of objectives and measures further complicates the situation.

Without some changes to slow down the required implementation pace, we are concerned that the HITECH incentive programs could get off to a rocky start, leaving many behind, particularly small community hospitals, rural providers, and physicians close to retirement age. As the voice of patients around the country, we wholeheartedly endorse the meaningful use goal of reducing health disparities. If that goal is to be realized, the requirements under the Medicare and Medicaid incentive programs must be seen as achievable with reasonable effort by hospitals and providers in all parts of the country, especially those in rural and underserved areas and those serving high numbers of Medicaid patients. Otherwise, instead of serving as an equalizer among hospitals, the HITECH Act could lead to a greater disparity between small, rural hospitals and large, urban hospitals.

In an effort to assist providers and push them in the direction of HER adoption, NPAF supports the idea of front-loading the Medicaid and Medicare incentive payments – especially for critical access hospitals and small physician practices in rural or underserved areas where an outlay for an EHR to comply with meaningful use may not otherwise be tenable. The front-loading of incentive payments is critical to laying the foundation of national HIT efforts and broadly fostering engagement in we hope will be a collective HIT endeavor. The development of EHR systems necessitates a major capitol investment for providers, yet we have not seen much solid economic data supporting the conclusion that EHR yield a return on the initial investment.

NPAF thanks CMS for its efforts to extend the Physician Quality Reporting Initiative (“PQRI”) beyond 2010 for physicians who qualify. We believe this is a good way to provide additional funding for eligible professionals who choose to participate in the Medicare or Medicaid EHR incentive program. The same is true of the incentives available to physicians under the Medicare eRx Incentive Program. We also support the use of incentives for physicians using certified EHR (web) portals, especially for smaller physician practices that may not have the upfront resources to support a customized EHR system.

Meaningful Use

NPAF generally supports the 23 hospital and 25 eligible professional objectives that compromise the NPRM’s meaningful use of electronic health record technology. We do think, however, that it is unreasonable to believe that all of the objectives can be achieved within a Stage 1 framework. Moreover, we are of the view that it will be extremely difficult for hospitals and professionals that fail to qualify for incentives under Stage 1 to catch up with program requirements or reap sufficient benefits from

incentive payments to finance adoption and use of an EHR. The overly aggressive timeline of the program likely will most harm those who need the most help.

Some of the measurements and outcomes detailed in the meaningful criteria and implementation specifications are straight-forward and easily attainable (such as electronic entry of a patient's preferred language, and drug-drug/drug-allergy interactions). NPAF believes these types of measures could easily be completed in Stage 1. We would respectfully suggest that other objectives and measures are much more challenging for providers to meet as part of Stage 1. Advanced clinical functions – i.e., demonstration of 5 types of clinical support – generally are feasible only at the end of a multi-year transition to EHRs, and should be pushed back to Stage 2. The same is true about computerized physician order entry capabilities. We also believe the proposed privacy and security requirements are overly burdensome for Stage 1 and may be more appropriate as a Stage 2 requirement, as would be reporting on clinical quality measures. The amount of resources required for hospitals and health professionals to move through the entire process of a comprehensive EHR rollout cannot be overlooked. NPAF supports incremental adoption of meaningful use, and supports additional incentives (such as are being provided for eligible providers in Health Professional Shortage Areas) for rural hospital and providers that will be starting out already behind in EHR technology and in steps required to achieve many of the meaningful use objectives and measures.

Hospital-Based Providers

It is unfortunate that the majority of hospital-based eligible professionals will not be able to qualify for Medicare or Medicaid payment incentives under CMS' interpretation of the HITECH Act. The law defines hospital-based eligible professionals as those who furnish substantially all of their services in a hospital setting (whether inpatient or outpatient) using the facilities and equipment, including the qualified EHR, of the hospital. The NPRM goes a step further to define hospital-based eligible professionals as those who furnish at least 90 percent of their services in the inpatient hospital, outpatient hospital, or emergency department setting but it ignores the secondary definitional requirement about using the hospital EHR.

We agree that certain hospital-based specialists – such as radiologists, pathologists and anesthesiologists who work exclusively in the hospital and do not typically see patients in an outpatient setting – should not be able to “double-dip.” However, the prohibition against payments for hospital-based professionals is problematic for primary care physicians and specialists, such as medical and radiation oncologists, who practice in outpatient clinics that often are not equipped with or connected to hospital EHRs designed specifically to serve the hospital's inpatient operations and the ancillary departments that support those operations. Separate EHRs designed to handle physician office functions are often used to support such clinics and hospital incentives tied to inpatient admissions will not be adequate to fund the implementation of such

systems or ensure their integration and interoperability with EHRs tailored to document inpatient services.

The NPRM provides that hospitals' total incentive payments are to be based only on a hospital's inpatient services. This payment structure alone belies the appropriateness of CMS' conclusion that the HITECH Act precluding incentives for health professionals practicing in hospital outpatient clinics. NPAF shares CMS' concern that hospital investment in outpatient primary care EHRs is likely to lag behind the investment in inpatient EHRs. We urge CMS to address the concern by backing away from its overly broad definition of a hospital-based eligible professional as any professionals who practice in an outpatient center or clinic owned by a hospital and operated as an outpatient department rather than a freestanding physician practice. If CMS does not believe it has the statutory authority to make this change from the proposal it has already put forth, we urge it to work with Congress to effectuate the necessary statutory changes.

Excluding physicians practicing in hospital ambulatory-care settings from eligibility for the HIT incentive payments will limit the benefit of EHR adoption in essentially all communities, but especially those rural communities where hospital outpatient departments are often the only available source of ambulatory care. It is counterintuitive to implement the HITECH Act in a way that circumvents a significant portion of the outpatient delivery system. We feel so strongly about the need to make incentives available under the final rule to eligible professionals who have chosen to practice in outpatient clinics that we are inclined to suggest delaying implementation of Stage 1 outcomes and measures until outpatient departments and physicians practicing in those departments can be fully integrated into the Medicare and Medicaid incentive programs.

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Thank you for the opportunity to submit formal comments to the CMS-0033-P. We strive to make dialogue with the agency about how EHR policies give voice to the concerns of Medicare beneficiaries dealing daily with the burdens of a chronic, debilitating or life-threatening disease. We would be happy to discuss our comments with you if you have any questions about our recommendations for improving Medicare beneficiaries' access to cancer care.

Respectfully submitted,



Nancy Davenport-Ennis
President and Chief Executive Office