

Commentary of the Primary Care Information Project on the Federal Electronic Health Record Incentive Program

To Whom It May Concern:

Since launching in 2005, the Primary Care Information Project (PCIP) of the New York City Department of Health and Mental Hygiene has grown into the nation's largest electronic health record (EHR) extension project. With public funding, we established a master contract with one commercial EHR vendor, and worked closely with their staff to develop the architecture for integrated registry functions, point of care decision supports for providers, and automated quality measurement. These tools enable even the single-doctor practices in our program to run population health management programs.

Through PCIP, over 1800 providers who serve Medicaid patients and the uninsured are live on an EHR. After implementation, PCIP provides on-site consulting to establish workflows that leverage the EHR to improve the health of their patients. This network of engaged EHR-enabled practices works with PCIP to pioneer initiatives that leverage the power of technology to accomplish public health goals, with a special focus on prevention, continuity of care, and cost reduction. The impact of these efforts is captured by automated, aggregated quality reporting from each practice to the Department of Health. All of this work has served to move providers in our program towards the principles of "meaningful use of an EHR," even before the term was defined in the Recovery Act. We are proud to have been selected to continue our work as a Regional Extension Center (REC)

Based on this experience, we write to express strong overall support for the measures and regulations promulgated by the Centers for Medicare and Medicaid Services for the Electronic Health Record Incentives Program. The goals are far-reaching and ambitious, but ambition is inherent to the mission of improving health outcomes and making health care affordable.

Before launching into the specifics of the regulations, we offer three overall principles to guide the implementation of the incentive program by CMS, supported by the Office of the National Coordinator.

1. **Transparency and Feedback**: Providers in PCIP consistently express confusion and concerns to us about the Meaningful Use rules and processes for submitting data to CMS. To overcome these concerns, CMS, in concert with State Medicaid offices, should:
  - a. Announce details of the operational "nuts and bolts" of determining eligibility, attestation of Meaningful Use and Clinical Quality Measures (for 2011), and payments as soon as possible, and through materials and media that are accessible to busy providers. The RECs should play a central role in disseminating clear signals from CMS.

- b. The Meaningful Use and clinical quality data should be presented back, with the added context of national and regional benchmarking, to motivate improvement and engage provider focus on the Meaningful Use criteria. Here, again, CMS should leverage the local dexterity of the RECs.
  
2. **Recognizing Interconnectedness:** Although CMS will pay incentives directly to providers, the achievement of Meaningful Use relies also on an interlocking network of EHR vendors, hospitals, laboratories, pharmacies and insurance plans that must coordinate and upgrade their systems, often at cost. CMS recognizes this complexity by lowering thresholds for Meaningful Use Measures that are more dependent on exchange infrastructure, but even with these adjustments many providers will not meet Meaningful Use due to failures by external entities that are beyond their control. CMS should:
  - a. Exert all available leverage to motivate and overcome barriers to participation by vendors, pharmacies, laboratories and hospitals in the processes required for Meaningful Use.
  - b. Accept the proposal by the Health IT Policy Committee to allow providers to defer a small number of specified measures to stage II Meaningful Use.
  
3. **Moving Beyond Meaningful Use:** The 25 Meaningful Use Measures for Eligible Professionals will engage physician attention and effort more effectively if CMS makes clear that each stands as a gateway to participation in pilot projects and rewards programs that build on a baseline of Meaningful Use to create tangible improvements in health and the affordability of health care. Providers that adopt an EHR through PCIP have had the opportunity to participate in pilot programs such as Health eHearts, which draws on EHR clinical data reward effective cardiovascular health care. Through such linkages, it will be clear to providers that the technology is a means to an end, and that end is specific and measurable improvements in health.

We strongly support several specifics of the regulations:

1. **Aligning clinical decision support rules with designated quality measures** – PCIP has worked with our EHR vendor to link clinical decision support to quality measures that are readily in the view of the provider within the EHR. This linkage has strengthened the focus of our quality improvement and pay-for-performance efforts.
2. **Reminders for preventive and follow up care** – This will spur revolutionary changes in practice workflow and begin to fundamentally expand the scope of

communication from medical practices to patients, which is currently confined to the examining room.

3. **Coordinating Medicare and Medicaid criteria** – This synchronization of criteria will allow technology vendors to focus on the single goal set, enabling economies of scale in reporting.
4. **90 day reporting period for Meaningful Use in 2011** – This provides an additional 9 months for Meaningful Use readiness by vendors, providers, health information exchange organizations and RECs, while allowing the most advanced providers to receive rewards as soon as possible.
5. **A range of options for the reporting of Clinical Quality Measures starting in 2012** – PCIP has developed a distributed query model for the collection of aggregate quality measures from our participating practices and encountered difficulties establishing uniform and reliable rates of transmission. CMS should be prepared to develop parallel systems, with constant testing for errors in data entry, coding, transmission and architecture, in order to compile this crucial national quality atlas.

Alongside our general approval, we have several points of concern, each grounded in our years of experience implementing and measuring EHR use with the objective of improving health outcomes.

#### Eligibility and Program Structure

1. **Avoid manual tracking of measures**– The NPRM estimate of burden affords only one hour each for the 8 measures that require manual tracking to establish a denominator for attestation of Meaningful Use in 2011. Our sense is that this is a dramatic underestimate. This tracking will add another routine clerical task to the work of the practice, which will consume substantial resources over the course of the 90 day reporting period. Instead, we propose that CMS establish standard denominators for these measures based on an algorithm with one-time inputs of patient volume, adjusted for patient mix and specialty, or judge these measures based on numerators alone. We raise these alternatives out of the following concerns:
  - a. That the burden of manual tracking will distract providers and their staff from their focus on patient care and population health and dissuade them from seeking Meaningful Use.
  - b. That manual tracking will be difficult to replicate, in case of audit, or to compare across practice sites.
  - c. That Meaningful Use rewards could have the unintended consequence of encouraging some providers to exclude some patient data from entry into the EHR, in order to prevent their inclusion in the denominator. PCIP's [Health eHearts Pay-for-Performance](#) program has rewarded physicians on the basis of numerators alone.
2. **Include free clinics within the eligibility requirements for Federally Qualified Health Centers** – These crucial safety net facilities would then qualify through their substantial care for the uninsured.

3. **Include providers delivering primary care in hospital outpatient clinics within Meaningful Use eligibility.** As the NPRM states (187), excluding these providers from reward upon reaching Meaningful Use jeopardizes achievement of the goal of near universal EHR adoption among primary care providers. There is ambiguity in the legislation regarding the definition of “hospital-based,” but we believe that in the ARRA [Conference Agreement](#), this ambiguity was substantially resolved. On Page 243 it is written, “The conference agreement, like the House and Senate-passed bills, prohibits payments to hospital-based professionals. This policy does not disqualify otherwise eligible professionals merely on the basis of some association or business relationship with a hospital. Common examples of such arrangements include professionals who are employed by a hospital to work in an ambulatory care clinic.” While it is true that hospitals furnish EHRs to providers delivering care in their outpatient clinics, we expect that these providers would commonly reassign these payments to their employers, as will be the case with providers delivering care in Federally Qualified Community Health Centers and group practices.
4. **Allow deferment of a small group of Meaningful Use Measures-** Many stakeholders are calling for a substantial weakening of Meaningful Use Criteria in which providers would have to meet only a quarter of Meaningful Use Measures. Writing from our experience as the nation’s largest EHR adoption project, we believe that a higher aim is realistic and warranted. However, to account for cases where barriers beyond the control of physicians prevent their achievement of Meaningful Use Measures, we endorse principles of flexibility put forward by the [HIT Policy Committee](#), which ensure that providers not abandon an entire category of Meaningful Use. Alternatively, CMS could establish payment tiers; offering a higher level of incentives to providers that achieve all Meaningful Use Measures and a lower level to providers that meet a minimum threshold.

### Meaningful Use Criteria

1. **ePrescribing** – PCIP has worked closely with independent medical practices throughout NYC to establish consistent electronic prescribing. The greatest barrier has been that many small independent pharmacies do not accept electronic prescriptions, because of technical or financial barriers. Until incentives, or regulations, are created to motivate the participation of small pharmacies in electronic prescribing, it will not be in the power of many providers to meet the 75% threshold proposed by CMS. CMS should lower this threshold in regions with a higher proportion of small pharmacies. If CMS allows providers to defer achievement of Meaningful Use Measures, e-prescribing should not be a mandatory objective in these regions.
2. **Patient Portal** – We propose that a patient portal or personal health record serve as the preferred mode of providing patients with electronic health information to achieve Meaningful Use. We are greatly concerned that offering patient their electronic health information on a USB key or CD could introduce, either

- intentionally or unintentionally, malicious files into the EHR, creating vulnerabilities to the security of patient information contained therein. The continuous antivirus procedures required to prevent these breaches will be onerous for the provider and his or her staff, and their failure threatens our health information systems with massive security breaches.
3. **Continuity of Care Document** – CMS should also require that health information be available to the patient in a Continuity of Care Document/Continuity of Care Record (CCD/CCR), to ensure that the patient has the ability to introduce his or her information into the PHR of his or her choice. Information in other formats may not be readable or executable by the patient on the computers available to him or her.
  4. **Preventive Care Reminders** – While we appreciate the importance of sending preventive care reminders to patients through a mode that will be useful to the patient, our experience is that patient outreach works best when it is grounded in the capacities and workflows of the practice. As such, requiring that the practice deliver reminders per patient preference is a more sensible goal for stage 2 Meaningful Use. Stage 1 Meaningful Use should allow the provider to choose the method of delivering the reminders.
  5. **Patient Outreach by Disease Status** – Rather than judging patient outreach on the basis of the portion of patients older than fifty years old having received reminders, this measure should require that a threshold percentage of patients with high prevalence, high mortality/morbidity chronic diseases receive reminders for follow up care. This would create a tighter focus on the drivers of our burden of disease and align more closely with Advanced Primary Care models. This change would also allow pediatricians, who are likely not to have a single patient older than 50, to meaningfully meet this measure.

Finally, there are several points in the regulation that require swift clarification from CMS, in order to dispel confusion among EHR vendors, providers and Regional Extension Centers

1. **Allowed Charges** – Whether the “Allowed Charges” that set a maximum of Meaningful Use Incentives through Medicare refers to charges billed, or charges approved and paid by CMS.
2. **Medicare Advantage** – Whether payments to a provider from a Medicare Advantage plan can contribute to the volume of Allowed Charges for the purpose of calculating maximum Meaningful Use rewards. We believe that they should.
3. **Insurance Eligibility** – Whether the Meaningful Use requirement that providers check insurance eligibility entails that the eligibility status is available within the EHR. We find that making eligibility checking within the EHR saves the practice time and ensures that the check is performed. CMS should be prepared to exert influence on the payers who do not enable this checking within the EHR. In recognition of this complexity, CMS should consider changing this measure to a Y/N attestation of a single eligibility check, or lowering the threshold.
4. **ePrescribing** – Whether the definition of “permissible prescriptions” for electronic prescribing includes medical supplies.