May 7, 2012

Submitted Electronically

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0044-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2 Notice of Proposed Rulemaking (CMS-0044-P)

The Community Healthcare Association of New York State (CHCANYS) welcomes the opportunity to submit comments on the Proposed Rule for the Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2. We support the efforts of the Department of Health and Human Services to improve the quality and efficiency of our nation's healthcare system through the use of information technology.

CHCANYS is New York State's Primary Care Association. We have offices located in New York City and in Albany, and serve as the membership organization for 60 FQHC's and FQHC Lookalikes in New York State. Our primary care network provides medical, dental, behavioral health, oral health and other comprehensive health care services to 1.4 million New Yorkers at over 500 locations.

We operate a large Statewide Health IT program for FQHCs in our state:

CHCANYS' Statewide HIT Program was launched in the fall of 2010, as an expansion of the NYC-based Primary Care Health Information Consortium (PCHIC). PCHIC operated from 2005-2010 as a source of technical assistance, training, peer learning, advocacy and fund development for NYC-based FQHCs. The Statewide Health IT Program has continued and expanded these services, becoming known and respected at local, state and national levels. CHCANYS communicates regularly on behalf of our members with Health IT leadership at CMS; HRSA, BPHC; NY State DOH; NYC DOHMH; the New York eHealth Collaborative; NACHC; and PCA colleagues across the country. Current Health IT programs at CHCANYS include the following:

1. Regional Extension Center: CHCANYS is a subcontractor to the New York eHealth Collaborative, working with 19 FQHCs in upstate New York to implement and become Meaningful Users of Electronic Health Records (EHRs).

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CHCANYS supports FQHCs statewide in becoming Meaningful Users through training and technical assistance via web meetings, face-to-face health center visits and detailed tools and educational materials on our website.

2. Center for Primary Care Informatics: CHCANYS Center for Primary Care Informatics (CPCI) will combine a data warehouse with extensive reporting capabilities and a wraparound program of technical assistance to support clinical quality improvement, health center planning, advocacy and fund development for our members statewide. The data warehouse will be interfaced to draw clinical, operational and financial data nightly from health center EHRs and will serve as a comprehensive repository for aggregated primary care data.

   This project has been identified as a priority by the CHCANYS Board of Directors, reflecting the desire to leverage the data now available through use of EHRs and Practice Management Systems to improve the quality of care we deliver and the health outcomes of our patients and to support FQHC efforts to become Meaningful Users. CPCI is currently in pilot with 11 FQHCs statewide.

3. Health Center Network of New York (HCNNY) – Nine FQHCs serving 301,500 patients at 64 sites statewide are working together as a HRSA-funded Health Center Controlled Network to meet complex and diverse challenges in the implementation and use of Health IT, and to create quality and value for all stakeholders. The HCNNY was founded by CHCANYS and continues as a program of the association.

4. Patient Centered Medical Home and Health Home - CHCANYS has partnered with the Primary Care Development Corporation to offer training and technical assistance relating to NCQA Patient Centered Medical Home (PCMH) recognition to FQHCs statewide. The Statewide Health IT Program is now working with CHCANYS' Quality Improvement (QI) Program to build capacity among QI staff to provide these services directly, and to negotiate packages of discounted consulting services for those members seeking more immediate support in achieving NCQA recognition.

   The Health IT Program has also run a statewide Health Home Collaborative which has focused since last fall on New York State's Medicaid Health Home initiative.

More than 92% of the FQHC's in New York State have implemented practice management and electronic health records. The success of HIT adoption in New York
State is based upon a collective model of IT support services, which incorporates group learning and sharing of best practices. Our technology programs cover system selection, planning, implementation and use. Much of our work now focuses on the "post go-live" optimization of EHR use, which includes the proper set-up and use of advanced features, many of which are required to achieve meaningful use as preliminarily defined. The following comments have been prepared based on our experience and the input of our members.

General Comments:

1. Measure requirements must match the capabilities of certified EHR technologies.
   We cannot support any MU objective or measure that is unachievable, either due to the external environment or the lack of a corresponding certification requirement for the EHR product. Included in this category are the following:

a. The objective that requires an EP to **"Use certified EHR technology to identify patient-specific education resources identified by certified EHR technology"** is not achievable in many of our health centers. Most patient education sites are geared towards patients with higher education levels than the majority of FQHC patients; in addition, for EPs who see patients with English as a second language, there is even less patient material available with almost none available through certified EHRs. We believe an exclusion should be developed for this objective.

b. **"The capability to submit electronic syndromic surveillance"** is offered as a Menu objective (with no exclusion) even though most public health agencies are not equipped to handle the electronic submission of data from the multitude of available EHRs. This lack of capacity at public health agencies will not be remedied by EHR certification requirements. The same holds true for the **Menu objectives relating to cancer registries and other specialized registries.** If the Menu objectives are to have no exclusions, they should all be achievable through the EP's certified EHR technology without dependence on external factors.

c. **Summary Care Record for Transitions of Care.** The objective that requires an EP **"who transitions their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organization affiliation and using a different certified EHR than the sender for more than 10% of transitions of care or referrals"** cannot be achieved by the EP's certified EHR alone, and is dependent on the actions of other EPs and other EHR vendors. The exclusion offered in the Proposed Rule ("Any EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period is excluded...") is not adequate to account for environmental factors that are beyond the EP's or EHR vendor's control.

Until an EHR's capability to send and consume summary of care records is EHR-vendor-agnostic and is a requirement for certification, providers should not be held accountable for the choices other providers make regarding EHR implementation and use. This requirement does not improve patient care. If the NPRM assumes the use of Health Information Exchanges as a substitute for EHR-to-EHR transmission, this requirement should be deferred until such time as HIEs capable of this function are widely available. In sum, neither the majority of EHR products nor HIE's have reached this level of maturity.

2. <u>Compliance with objectives and measures must not be dependent on patient use of Health IT.</u> It is not within the EPs power to require that a patient use Health IT in a specific manner. In addition, the language barrier cited in 1, above, will make it impossible for many health center EPs to meet these measures.

There are two examples in the proposed measures:

"A secure message was sent using the electronic messaging function of certified EHR technology by more than 10% of unique patients seen..." This requirement is predicated on the assumption that patients have the means and desire to send a message to their provider. Meaningful Use should not be dependent on patients' actions. If the

decision is made to keep this requirement, at the very least an exclusion should be provided for language barriers, no access to the internet or clinical condition.

"More than 50% of all unique patients are provided timely online access to their health information...10% of all unique patients seen by the EP during the EHR reporting period...view, download, or transmit to a third party their health information." This Stage 2 measure is unreasonable for community health center providers. Health centers support populations frequently with limited access to the internet and email. In addition these populations frequently have language barriers that prevent use of a portal. Regarding the second half of the measure (10% of patients view, download or transmit...) the determination of an EP's Meaningful Use should not be dependent on patients' actions. We recommend that the measure be changed to require a provider to attest that a mechanism is available for online access. If the decision is made to keep this requirement as it currently is written, an exclusion for language barriers, socioeconomic barriers to the internet or health condition should also be provided.

3. Assignment of Incentive Payments to EP Employer:
   While we are appreciative that the Final Rule for Stage 1 Meaningful Use (MU) allowed Eligible Providers (EPs) to assign their incentive payments to an employing organization, the process developed in our state as a prerequisite to this assignment is cumbersome and time-consuming and for the last 4 months has drained resources from the health centers and CHCANYS that would have been more productively used in bringing the health center providers to Meaningful Use.

   (For more detail on the process, you may visit the CHCANYS website at www.chcanys.org to view instructions we wrote and compiled to explain the steps to our members; then imagine a health center with dozens of EPs undertaking this registration and attestation for each EP.)

   We are requesting that a process similar to that for hospital-based EPs be developed for EPs practicing in FQHCs or Rural Health Centers. For example, FQHCs and RHCs could have incentive payments calculated as a base amount and an additional per-visit amount, just as hospital incentives are calculated as a base amount and a per-discharge amount. As with hospitals, any EP who provides more than a certain percentage of his/her services in an FQHC or RHC would be considered part of the FQHC/RHC incentive payment; only those EPs who provided less than or equal to that percentage of their services in an FQHC or RHC or hospital would be eligible to apply for the EP incentive payments. The Final Rule for Stage 1 stated that the Medicaid and Medicare programs could use claims data to determine which providers were hospital-based. We expect that claims data could also be used under our proposal to determine whether a provider is "FQHC-based".

4. Group Reporting Options for Clinical Quality Measures and Meaningful Use Core and Menu Objectives.
   We are in favor of the Group Reporting Option for Clinical Quality Measures (CQMs) which allows the reporting of CQMs at the group, as opposed to individual EP, level. We note, however that the Group Reporting Option for MU Core and Menu Objectives is intended to allow a batch reporting of each individual EP's core and menu objective data, but that each EP would still have to meet the required meaningful use thresholds independently. This option does not permit any EP to meet the required meaningful use

thresholds through the use of a group average or any other method of group demonstration. While we are in favor of the administrative simplification batch reporting allows, we believe that FQHCs and RHCs should receive the same options as hospitals in reporting MU Core and Menus Objectives at the group level.

5. Scope of Practice. Dental providers are eligible for the Meaningful Use incentive; however, many of the requirements are not clinically relevant for this specialty. Core measures should have appropriate exclusions for this population. For example, they should be able to provide the patient a treatment plan in lieu of the medical clinical summary or have an exclusion. In addition, the "no known problems" should be clarified to include "no known dental problems" or limited to the scope of the provider's specialty.

6. Quality Measures. We agree that the measures should align with the existing quality programs. These should include Uniform Data System quality measure reporting required by HRSA of federally qualified health centers, in addition to PQRS and NCQA measures.

7. Denominator Proposal. The four proposed denominator options for the meaningful use objectives include unique patients, number of orders, office visits and transitions of care/referrals. We believe that the number of unique patients is the best denominator. The number of office visits would be acceptable but not preferred.
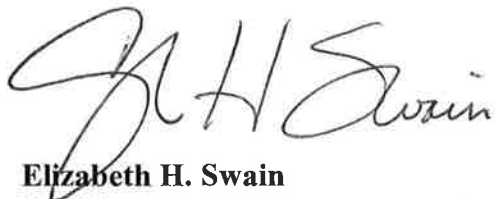
Comment on Specific Objective/Measures:

1. The Proposed Rule requests comment on the burden and ability of including a patient's disability status as part of the data collection for the Demographics measure. Our EPs have responded that it is impossible to report on disability status (in whose eyes is the patient disabled?). We would be in favor of documenting on specific areas of disability if it would improve clinical care. A broad spectrum encompassed under the term "disabled" does not provide enough information to improve care and would cause too much variability in responses to be relevant.

2. We are very pleased to see the age threshold for patients required to have **blood pressure measurement** in the **Vital Signs** measure has been raised to 3 years.

3. The **patient reminder** measure should include the phrase "preventive/follow-up care" that appears in the objective, and it should be stated explicitly that an upcoming appointment qualifies as "clinically relevant information" warranting a reminder.

4. We are opposed to the new menu requirement that more than 40% of images ordered by the EP be accessible through the EHR. Our clinicians have told us that reports are more important to providing care than the actual image itself. It is also a financial burden to view or store images due to file size, and in many cases a provider other than a radiologist should not be interpreting complex images/imaging data.

5. The proposed Rule requests comment on "whether **the problem list** should be extended to include, when applicable, **functional and cognitive limitations** or whether a separate list should be included for functional and cognitive limitations. Our EPs have responded that it is best to use ICD-9 diagnostic codes (e.g. dementia) since they are commonly used and cover the majority of problems, otherwise such a listing is burdensome and does

not exist in EHRs. The implementation of ICD10 should be sufficient to identify functional and cognitive limitations.

6. Regarding **clinical summaries,** our EPs question the utility of the care summaries available in the EHR to the patient. The current clinical summaries capture medical data, but patients need non-medical terminology, and easy-to -read, actionable items. Again, the problem is compounded for a patient who can't read or has a very low literacy level, or speaks English as a second language or not at all. In addition, the 24-hour turnaround on this measure is extremely short and only achievable if the EHR will print the summary before the note is closed by the EP.

7. **Incorporate clinical lab-test results as structured data.** Providers that do not have access to a local laboratory that can provide data electronically will be faced with a burden of manually entering all lab results. This is especially true in locations with limited lab options. An exclusion should be included to address the lack of availability of structured data from the lab vendor.

8. The threshold for **e-prescribing** may be too high for FQHCs in urban areas due to the large number of pharmacies that would need to be identified for an urban provider to meet this threshold. In addition, many patients want paper prescriptions in hand in order to shop around for the lowest price.

Sincerely,

Elizabeth H. Swain
President & Chief Executive Officer