June 25, 2009

David Blumenthal, MD, MPH
National Coordinator
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Suite 729D
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Blumenthal:

The Medical Group Management Association (MGMA) is very supportive of physician practice adoption of health information technology (HIT) to improve health care quality and efficiency and streamline wasteful administrative processes. We believe that the financial incentives included in the American Recovery and Reinvestment Act of 2009 (ARRA) will act as an important catalyst facilitating the transition of large numbers of physician practices to this important technology.

MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA's more than 22,000 members manage and lead 13,700 organizations, in which more than 275,000 physicians practice. MGMA's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them.

We offer the following recommendations to assist your work in appropriately defining "meaningful use" and developing an overall HIT framework that will best meet the needs of a very complex and diverse health care system.

General Recommendations on Meaningful Use

- **Inclusion of Efficiency Measures (Administrative Data) in Meaningful Use** - We recommend that administrative efficiencies be included as a goal of meaningful use as well as clinical improvement.

  Currently, the Certification Commission for Health Information Technology (CCHIT) includes the Council for Affordable Quality Health Care's Committee on Operating for Information Exchange (CAQH CORE) Phase One rule requirements on patient insurance eligibility. CCHIT tests that the system "shall provide the ability to query and receive electronic medical insurance eligibility information… IOEP will reconcile with IO-AM 09.13. X12 270/271/ CAQH CORE."

  Additional measures could be added to the certification process that provides for the ability of the system to integrate a standardized, machine-readable health identification card. Although this might not be feasible for 2011, it should be considered for the later phases of the program.

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Meaningful use requirements could include a broader set of administrative requirements including automation of the practice workflow, CAQH CORE Phase Two insurance eligibility verification specifications, streamlined (real-time) claims adjudication processes and electronic payment remittance and payment capabilities.

- **Support for a Phased-in Approach to Meaningful Use** - In order for the maximum number of physician practices to adopt HIT and take advantage of the ARRA financial incentives, we support a phased-in approach to the meaningful use requirements. At the same time, however, it is critical that the 2011 meaningful use criteria not be so stringent and so onerous that they act as a deterrent for practices to adopt HIT. In addition, more stringent requirements for meaningful use in later years should be developed through a consensus process and should be fully tested prior to implementation.

- **Application of the Program to Additional Providers** - A very common and successful model of patient care includes utilization of mid-level providers (i.e., registered nurses, nurse practitioners). These providers take full advantage of the EHR technology in the practice as they complete their duties treating patients. In addition, practices that have purchased EHRs report that mid-level providers are included in the vendor contract calculation of the per-clinician purchase cost and ongoing maintenance costs. Accordingly, we strongly encourage the extension of the requirements and incentive payments to include mid-level providers in the incentive program.

- **Identify Certification Options** - MGMA was one of the initial endorsers and participants on the Certification Commission for Health Information Technology (CCHIT). We believe that CCHIT's public and incremental approach to the development and deployment of certification criteria has been extremely effective for both the physician practice and vendor communities.

  Having another entity start from scratch to develop appropriate testing criteria would be time consuming and duplicative of the current CCHIT effort. Physician practices are familiar with the CCHIT brand and have incorporated CCHIT certification into their core set of purchasing deliberations. We strongly urge you to support the continuation of CCHIT's important work and name this organization as the sole EHR certifying body.

  To improve the current certification process, we recommend:

  - Significantly increase funding for the CCHIT should the Secretary identify CCHIT as a certifying entity.

  - Incorporating usability criteria into CCHIT's testing criteria.

  - Support for CCHT's newly released three-tiered certification process. We were pleased to see CCHIT develop alternative certification processes to enable specialty-specific, module-based and self-developed EHRs to be certified at a reduced cost.

  - Should CCHIT (or any other designated certification entity) be

unable to develop and deploy medical specialty-specific certification processes by 2011, we encourage the Secretary, in the interim, to work with the appropriate medical specialty societies to identify a set of specialty-specific criteria for "certification" by the individual specialty societies.

- **CCHIT Certification of Practice Management System Software** - To decrease health care costs and improve administrative efficiencies, we recommend that CCHIT receive additional funding and be directed to develop a certification program for practice management system software.

- **Institute a Process to Test Systems** - We recommend that the government develop a process where physician practices could submit their software specifications and test their ability to meet the meaningful use requirements. They then would receive timely and actionable feedback regarding their ability to qualify for the incentive payments.

- **Demonstration of Meaningful Use** - Creating a process that is effective yet simple for physician practices to demonstrate meaningful use will be a critical component of a successful incentive program. We recommend that attestation and/or survey instruments serve as the primary methods of demonstrating meaningful use. This would be especially important for the initial phases of the program and could be verified through an audit process.

- **Closely Monitor Industry Progress** - What has been outlined in the legislation for 2011 and beyond is nothing less than a transformation of the health information infrastructure of the nation. It will be critical to continuously assess the readiness of physician practices, other eligible providers, and the EHR software vendor community to meet this challenge and quickly identify barriers to the successful adoption of HIT and solutions to those barriers.

<u>Specific comments on the Matrix</u>

- **Percentage Thresholds for Various Measures** - Throughout the matrix, recommended measures refer to unspecified percentage thresholds that providers would have to meet in order to qualify for the incentives. We recommend that these measures correspond exactly to the PQRI agreed-upon measures. For example, the 2011 measure "% of females over 50 receiving annual mammograms" should mirror the PQRI measure and permit the clinician to report:
    - "Numerator Quality-Data Coding Options for Reporting Satisfactorily:
        - Mammogram Performed CPT II 3014F: Screening mammography results documented and reviewed OR Mammogram not Performed for Medical Reasons
        - Append a modifier (1P) to CPT Category II code 3014F to report documented circumstances that appropriately exclude patients from the denominator.
        - 3014F with 1P: Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies). OR
        - Mammogram not Performed, Reason not Specified

- Append a reporting modifier (8P) to CPT Category II code 3014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
- 3014F with 8P: Screening mammography results were not documented and reviewed, reason not otherwise specified"

If the meaningful use measures are designed not to correspond to the established PQRI definitions, they should be modified. We recommend that these types of measures follow the language in such 2011 measures as "% of smokers offered smoking cessation counseling" and require that a minimum percentage of patients be "offered" or "counseled" for such tests as cancer screening and mammograms.

We have concern with the 2013 measure "% of encounters where fill data accessed." The "fill-status" transaction that allows a clinician to ascertain whether a patient has had their prescription filled can be a very important clinical tool. However, our members report that the need to utilize this transaction depends very much on the specialty and the provider's patient mix. As well, not all pharmacy's have the ability to conduct this transaction electronically. As a consequence, we recommend that the measure be "Implemented ability to conduct fill-status transactions electronically."

In addition, we have a concern with the 2013 measure "Inappropriate use of imaging (e.g., MRI for acute low back pain). While MGMA is generally supportive of efforts to incorporate clinical guidelines that are transparent and developed in a collaborative manner as an alternative to "black box"-type prior authorization programs for imaging, any measure must be evidence-based, broadly accepted, clinically relevant, actionable, continually updated and developed by practicing physicians though a transparent, multispecialty consensus process.

- **Patient Access to Information** - Although MGMA is supportive of a patient's ability to access their health information, we are concerned about the potential impact on care delivery and administrative burdens associated with certain draft patient access measures. First of all, the 2011 measure "% of all patients with access to personal health information electronically" is unnecessary as patient access to their health information in an electronic form is now a requirement under the new privacy provisions included in ARRA. In addition, many patients, especially Medicare patients, do not want their information in an electronic format. A more appropriate measure would be "% of patients offered electronic access to their personal health information."

  The 2013 measure "% of patients where summary care record is shared" presupposes that patients and/or their other care providers have requested this. A provider should not be penalized when their patients are informed of a service, but choose not to take advantage of it. We recommend the measure read "% of patient where summary care record sharing has been offered."

- **Reliance on Third-Party Compliance to meet Minimum Threshold** - Regarding the draft measure "% lab results incorporated into EHR in coded

format" we are concerned that providers will be relying on outside labs having the ability to send codified lab results. As not all labs will have this ability, we recommend that the measure language be modified to read "Implemented ability to incorporate lab results into EHR in coded format."

- **Avoidance of Overly General or Unnecessary Measures** - The 2013 measure "Inappropriate use of imaging (e.g., MRI for acute low back pain)" is not specific and overly subjective. In addition, the 2011 measure "Full compliance with HIPAA Privacy and Security Rules" is unnecessary as covered entities are already required to be in full compliance with these federal regulations. Finally, requiring a provider to "Conduct or update a security risk assessment and implement security updates as necessary" should not be a meaningful use measure as this is already required by law under HIPAA.

- **Program Disqualification due to a HIPAA Investigation** - We are very concerned that meaningful use, and a provider's ability to qualify for the ARRA incentives, may be directly impacted due to an alleged privacy violation. This draft provision is synonymous to "guilty before proven innocent." The Office of Civil Rights (OCR) has reported that thousands of claims against providers have been dismissed due to no regulatory applicability and thousands more have been resolved with a minimum of action required by the covered entity. In addition, in some cases it has taken the OCR two or more years to investigate and resolve a privacy complaint.

In conclusion, MGMA strongly supports the objectives of the ARRA incentive programs to stimulate adoption of HIT. However, there is a risk that a large percentage of physician practices would be excluded from the program should the qualifications for participation be overly stringent or the process too onerous. We believe an appropriately-defined and phased-in approach to the meaningful use requirements will allow a wide array of organizations to take advantage of the incentive program. Should you have any questions regarding our comments, please contact Robert Tennant at 202.293.3450 or rtennant@mgma.com.

Sincerely,

William F. Jessee, MD, FACMPE
President and Chief Executive Officer