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March 12, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
Baltimore, MD 21244-8013

Re: Proposed Regulations for the Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule (RIN 0938-AP78)

Dear Administrator Frizzera:

DMAA: The Care Continuum Alliance respectfully submits these comments in response to the Notice of Proposed Rulemaking (NPRM) for the Centers for Medicare and Medicaid Servicesô(CMS) incentive program for the Meaningful Use of electronic health records (EHRs). The proposed regulations, issued pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act in the American Recovery and Reinvestment Act (ARRA), represent an important step in efforts to increase adoption and use of health information technology to improve health outcomes and increase the quality of health care delivery.

Background

DMAA members provide services along the entire continuum of care, including wellness, disease management and complex case management. DMAA members include wellness, disease management and population health management organizations, health plans, physician groups, hospitals, labor unions, employer organizations, pharmaceutical manufacturers, pharmacy benefit managers, health information technology innovators and device manufacturers, academicians and others. These diverse organizations share DMAAôs vision of aligning all stakeholders to improve the health of populations. Our members seek to improve health care quality and contain health care costs at a population level by providing targeted interventions and services to individuals who are well, at-risk for or managing one or more chronic conditions.

DMAA strongly supports widespread adoption of health information technology by health care providers to improve health outcomes and to increase the quality and efficiency of health care service delivery. The enactment of HITECH presents opportunities for HIT policy and implementation efforts to move toward an interoperable nationwide health information technology infrastructure. DMAA believes that the

adoption of HIT in isolation will not result in improved outcomes, quality and safety. Rather, DMAA asserts that connected, coordinated HIT utilization, integration of incentives for health care providers and reimbursement reform will transform our health care system to enable health management at a population level.

General Comments

The proposed rule defines stage 1 Meaningful Use criteria for electronic health records (EHRs) and establishes requirements for the Medicare and Medicaid incentive programs. DMAA believes these definitions and requirements will establish a foundation and accelerate the adoption of HIT technologies throughout the health care system. DMAA supports the CMS stage 1 health outcomes priorities, including improving quality, safety and efficiency, and reducing disparities; engaging patients and families; improving care coordination; and improving population and public health.

The linkage of health care outcomes priorities with care goals, objectives and clinical quality measures lays the groundwork for attainment of Meaningful Use. DMAA urges CMS however, to be cognizant of the alignment of quality improvement efforts and reporting requirements to ensure that the health outcome priorities and objectives result in the stated care goals. Specifically, DMAA is concerned about the NPRMôs emphasis on the production of patient lists and on information exchange without taking into account decision-support or evidence-based algorithms to ensure data is used to improve patient care and outcomes. Providers need systems that will enable the analysis of data and systematically identify care improvement opportunities. As CMS develops stage 2 and 3 regulations, we suggest the consideration of additional clinical measures (as they are developed) that will provide greater evaluation of patient outcomes and ultimately better decision support tools.

Further, DMAA anticipates significant expansion of functionality and reporting requirements in stage 2 and 3 rulemakings. The current NPRM outlines areas of focus for stages 2 and 3 including disease management, clinical decision support, medication management, patient access to information, transitions of care, quality measures, research, quality and safety improvements and improving population health outcomes. DMAA members currently possess functionality and expertise in many of the areas of focus outlined for stages 2 and 3. To that end, we offer the experiences of the population health improvement community as a resource to CMS as the agency moves forward with development of stages 2 and 3 criteria.

Specific Comments

Shared Definitions and Methods: CMS outlines in the NPRMôs preamble the adoption of a common Meaningful Use definition for use in the Medicaid and Medicare programs. DMAA strongly supports this proposal for a common definition of meaningful use under Medicare and Medicaid to reduce the administrative burden and complexity in the incentive program as well as to foster widespread and rapid adoption. For similar reasons, DMAA also supports common methods for demonstration of the stage 1 criteria for Meaningful Use as discussed in section 495.8.

Recommendation: CMS should adopt the common definition of Meaningful Use for the Medicare and Medicaid programs and should adopt common methods of demonstration of stage 1 criteria.

Avoiding duplicative quality reporting requirements from Federal and State governments:
DMAA believes that the statute and the proposed rule have taken the appropriate steps to avoid duplicative and redundant reporting requirements, where possible. Putting additional administrative burdens on health care providers takes away valuable and often limited time for patient care. Further, the proposed rule correctly states that coordination between Medicare and Medicaid where possible will result in greater alignment, consistency and efficiency.

Eligible Professionals (EPs):
The goals of the NPRM can only be achieved with electronic coordination of providers across sites and care functions ï the full continuum of care. The NPRM permits incentive payments for eligible professionals (EPs) and eligible hospitals (EHs) but excludes provider physicians who provide 90 percent or more of their care services in a hospital setting. The NPRMôs health outcomes priorities, care goals, objectives and measures require incentivizing as many physicians as possible to adopt EHR capabilities. Further, while DMAA appreciates the statutory limitation on the definition of eligible professional (EPs) in the proposed regulation, DMAA suggests that HHS and CMS take all possible discretionary measures to encourage other health care professionals (such as diabetes nurse educators, nurse practitioners, pharmacists, physician assistants, dietitians, case managers and social workers) who provide health support services as part of an interdisciplinary health care team to be users of EHRs.

Recommendation: Provider eligibility should be determined by type of service provided rather than by location of service and should include non-physician clinicians and providers.

Future Rulemaking and Flexibility:
The NPRM proposes 23 objectives for hospitals and 25 objectives for eligible professionals. DMAA recognizes that health care providers and vendors need adequate time for the development, testing of systems and/or functionalities, as well as the ability to integrate those into clinical processes. DMAA encourages the agency to recognize these time constraints as well and provide a roadmap and additional guidance on these critical components of the rule.

DMAA shares concerns outlined by the HIT Policy Committee (HITPC) regarding the importance of flexibility in the ñall-or-nothingò approach. The final stage 1 regulation should allow some flexibility in the ñall or nothingò approach to earning incentive payments. Without some flexibility, EPs and hospitals are presented with the enormous challenge of adoption, integration and reporting of performance benchmarks in a

compressed timeframe which could hinder adoption by some providers and lead to penalties for those who fail to become meaningful users.

> Recommendation: CMS should include greater flexibility in stage 1 requirements and provide incentives payments for achieving a high or substantial percentage of the stage 1 Meaningful Use measures.

Attestation
With respect to the requirements for submission of clinical quality measures for the first year, CMS should provide further guidance on the structure and form of the attestation methodology that will be required to receive the incentive payment discussed in the preamble. We seek this clarification to help our members work with clients to become meaningful users but also to provide an indication of likely stage 2 and 3 reporting structures.

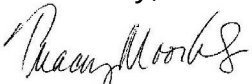
> Recommendation: CMS should provide clear and detailed guidance on the required structure and form of the attestation methodology.

Inclusion of the patient-specific education resources objective (Section 495.6)
DMAA is concerned that the proposed regulation did not adopt the HITPCôs recommendation for the inclusion of the objective to provide access to patient-specific education resources. Patient-specific education resources lead to better-educated and active patients. DMAA further believes that providing patients with decision aids and patient-specific education resources is a central component to the proposed ruleôs stated objective and health outcome priority of patient empowerment, engagement and accountability. DMAA respectfully disagrees with the NPRMôs assertion that there is a ñpaucity of knowledge resourcesòavailable. In fact, resources that are condition-specific, actionable and culturally competent are readily available and currently being integrated into EHRs. DMAA would support the HITPC recommendation of February 17, 2010, to require EPs and hospitals to report on the percentage of patients for whom they use the EHR to suggest patient-specific education resources.

> Recommendation: CMS should adopt the HITPC recommendation to require EPs and EHs to report on the percentage of patients for whom they use the EHR to suggest patient-specific education resources.

We appreciate the opportunity to provide these comments and are available to assist the Department as it works to finalize the regulation.

Sincerely,



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