Response to "Medicare and Medicaid Programs: Electronic Health Record Incentive Program-Stage 2" NPRM (RIN 0938-AQ84)

Submitted via Federal eRulemaking Portal

May 7, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attn: CMS-0044-P, PO Box 8013
Baltimore, MD 21244-1850

Dear Secretary Sebelius:

The North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA) is a nationally-recognized nonprofit consortium that serves as an open, effective, and neutral forum for health information technology initiatives that improve health and care. NCHICA is comprised of over 230 member organizations representing the many sectors of the healthcare industry, including covered entities like providers and health plans, as well as government agencies, clearinghouses, business associates, research organizations, health care vendors, and attorneys.

NCHICA's comments on this Notice of Proposed Rulemaking (NPRM) are the result of a collaborative effort from NCHICA's various and diverse member organizations, which have considerable combined expertise in the various aspects of healthcare delivery, healthcare information technology, and the HIPAA regulations.

NCHICA'S COMMENTS ON THE NPRM

NCHICA commends the Department of Health and Human Services (the Department) on the intent behind these proposed implementing regulations for the Meaningful Use Stage 2 program. As follows, in response to the Department's request for comment to the NPRM, NCHICA is providing comment on the following topics/measures:

1. CPOE,
2. Timely Access to Health Information,
3. Clinical Summaries for each Office Visit,
4. Summary of Care / Improved Care Coordination.

NCHICA believes that clarifications in these areas will better enable eligible providers and hospitals to meet MU Stage 2 while improving the quality of patient care.

CPOE UNDER PROPOSED 42 CFR § 495.6(j)(1)

In general, NCHICA supports this measure. However, we would like to clarify that a provider may authorize support staff to perform the ordering on their behalf. The proposed language restricts the ordering to individuals having a license. We ask CMS to clarify this measure by adding additional language to allow other users (RNs, LPNs, etc.) to order on behalf of an eligible provider (EP) on a case-by-case basis following provider discretion.

TIMELY ACCESS TO HEALTH INFORMATION UNDER PROPOSED 42 CFR § 495.6(j)(10) and 42 CFR § 495.6(l)(8)(i)

NCHICA agrees that encouraging patient engagement is a core objective of healthcare, and praises this measure's inclusion in the Stage 2 measures. However, we are concerned with the requirement that more than ten percent of patients must view, download, or transmit their health information. We do not see how providers can enforce that patients perform these actions, even for such a small percentage of patients. Rather, providers can only enable portals for specific patients and encourage them to use the portals as directed by the measure. We recommend that the measure at 495.6(j)(10)(ii)(B) be removed, while retaining the measure at 495.6(j)(10)(ii)(A).

CLINICAL SUMMARIES FOR EACH OFFICE VISIT UNDER PROPOSED 42 CFR § 495.6(j)(11)

NCHICA agrees with CMS that patients should be provided a copy of their clinical summary following an office visit. However, we are concerned by the impact the proposed measure will have on provider workflows. MU Stage 1 required that clinical summaries had to be provided within three business days for 50 percent of office visits, whereas the NPRM proposes requiring clinical summaries within 24 hours for more than 50 percent of office visits. We are concerned that this compressed timeline is not practical on the staff workflow. In addition, we point out that the proposed language does not specify "business", so calendar days are expected—possibly leading to additional provider workload to send clinical summaries on weekends or holidays.

We ask CMS to consider two alternate measures. Either:

- Change the measure to read "Clinical summaries provided to patients within two business days for more than 50 percent of office visits," or
- Change the measure to read "Clinical summaries provided to patients within three business days for more than 80 percent of office visits."

We prefer the latter recommendation, as this language does not require restructuring of workflow but rather mandates more efficiency in the process as a greater number of patients will receive clinical summaries. NCHICA believes that providing *more* patients with their clinical summaries is to be preferred over providing a few number of patients their clinical summaries *quicker*.

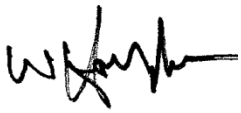
SUMMARY OF CARE / IMPROVED CARE COORDINATION UNDER PROPOSED 42 CFR § 495.6(j)(14)(ii)(B) AND § 495.6(l)(11)(ii)(B)

NCHICA appreciates the Department's efforts to encourage market diversity by requiring EPs and eligible hospitals to transmit 10% of their referrals to a recipient with no organizational affiliation with the EP or eligible hospital and uses a different CEHRT vendor than the sender. However, NCHICA believes the proposed measure could compromise patient care and is not in the best interest of providers. Providers typically do not know the vendor being used by the referral recipient, so simply to comply, providers may have to drastically alter their referral patterns. Within a jurisdiction or natural referring market, an EP may not have any referral recipients that do not have an organizational affiliation or use a different CEHRT vendor. In addition, we believe that, when an EP is making a referral, vendor choice should not be a factor in their decision. Rather, quality of care and convenience to the patient should be controlling factors. We are concerned that patient care may be compromised by EPs being forced to make sub-optimal referrals simply to meet this measure. Due to our concerns, we ask CMS to strongly consider removing this measure from MU Stage 2.

SUMMARY

NCHICA appreciates that the Department issued this NPRM for Meaningful Use Stage 2. The member organizations of NCHICA include covered entities, business associates, research entities, and aggregators of health data, as well as other entities that support them every day. NCHICA has carefully and extensively reviewed the NPRM document for Stage 2 Meaningful Use measures. We agree with most but have identified a select few that may be problematic to implement and cause concern among providers (and other key stakeholders) for the reasons stated in our response. We feel these may be problematic as they may adversely affect workflow, not be feasible to implement, have thresholds that are too high or cannot be accomplished in the time frame suggested. To that effect, we have listed alternate criteria for these measures and strongly urge that CMS seriously considers our suggestions during the final rule decision-making process.

Respectfully submitted,



W. Holt Anderson
Executive Director