

November 12, 2009

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
200 Independence Avenue, SW
Suite 729D
Washington, DC 20201

Dear Dr. Blumenthal:

As the nation's principal voice for medical group practice with 22,500 members managing and leading 13,700 organizations, in which almost 275,000 physicians practice, the Medical Group Management Association (MGMA) is very supportive of physician practice adoption of health information technology (HIT). However we are very concerned about the implementation process for the Medicare and Medicaid electronic health record (EHR) incentive programs currently under development. We believe that an inappropriate definition of meaningful use and inefficient administration of the program will lead to failed implementation of the American Recovery and Reinvestment Act of 2009 (ARRA) and result in the needless squandering of resources and significant disruption to the nation's **healthcare** system.

It is clear that the key goals of these health IT investments are to improve health care quality, control growth in costs, enhance the efficiency of health care administration, stimulate innovation, and ensure the privacy and security of patient information. At the same time that the definition supports these goals, meaningful use should also be verifiable without creating an undue burden on clinicians and physician practices. This is especially critical in the first years of implementation. We offer the following recommendations to assist in the development of the meaningful use definition and the creation of an implementation process that will meet the needs of a very complex and diverse health care system.

Recommendations

- Focus criteria on value and achievability – Meaningful use measures should have a highly predictive and demonstrable value for improving the nation's health and efficiency. The meaningful use criteria must set a trajectory of measurable targets toward those objectives. In this effort, goals for health improvement should go hand-in-hand with the ability for physicians to integrate these measures into their workflow with minimal disruption or cost.
- Avoid reliance on third party compliance - Several of the draft meaningful use criteria require, for example, the reporting of percentages of patients undergoing specific tests. We strongly encourage you not to impose arbitrary "thresholds" that physicians would have to meet for the reporting

HEADQUARTERS
104 Inverness Terrace East
Englewood, CO 80112-5306
phone: 303.799.1111
fax: 303.643.4439

GOVERNMENT AFFAIRS
1717 Pennsylvania Avenue
North West, Suite 600
Washington, DC 20006
phone: 202.293.3450
fax: 202.293.2787

www.mgma.com

of these types of measures. In the case of patients receiving tests, for example, physicians clearly cannot force patients to undergo tests which (i) may be physically uncomfortable for the patient, (ii) one that the patient objects to, or (iii) one for which the patient's health plan covers only part of the cost, or none of the cost.

- Selection of criteria already in widespread use – It is critical to avoid imposing criteria that do not have widespread experience in the small and rural clinical settings. To ensure that meaningful use can be successfully adopted in a wide range of practice settings, including small physician and rural practices, we strongly encourage you to adopt the approach taken through the government's electronic prescribing rulemaking process. As set out in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the HHS Secretary is only to adopt standards that have wide industry usage and to conduct pilots to determine the applicability of any additional standards. We believe a similar approach for determining appropriate meaningful use criteria should be adopted.
- Selection of appropriate administrative criteria –The administrative transactions currently outlined in the meaningful use matrix that physicians would have to report do not take into account the reality of current practice workflow or the inefficiency of the current standards themselves.
 - In the case of the electronic claim standard mandated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the ANSI X12N 4010A1 837, the majority of small and medium-sized practices currently utilize a clearinghouse or billing service to submit claims to health plans for payment. In many cases these claims originate as paper CMS 1500 forms or other, non-HIPAA compliant formats. In addition, the current compliance date for the latest iteration of the HIPAA 837 standard (5010) is not until Jan.1, 2012, well after the 2011 start date for the EHR incentive program.
 - The current patient insurance eligibility verification standard (ANSI X12N 4010A1 270/271) is not widely used by providers because of the lack of standardization among health plans. While this standardization issue has been addressed somewhat by the Council for Affordable Quality Healthcare Committee on Operating Rules for Electronic Transactions (CAQH CORE), the CORE operating rules remain voluntary for health plans and to date not widely used in the industry. As with the 837, the compliance date for the 5010 version of the 270/271 transactions standards is not until Jan. 1, 2012.
- Institute a pilot – Once the final rule is published, and well before to the 2011 program start date, we believe that the government should conduct a pilot with a small number of vendors and in a variety of physician practice settings to ensure that the process of demonstrating meaningful use is achievable and practical. This pilot could assist in determining potential roadblocks to program success and identify solutions to those roadblocks.
- Program logistical support - To avoid physicians encountering problems during the meaningful use reporting process, we believe that the government should:

- Ensure timely responses from CMS to physicians once data are submitted in support of their meaningful use reporting requirements.
 - The government must be ready to accept meaningful use data in late 2010 in order for physicians to send test data, receive feedback from an appropriate government agency and still have sufficient time to take the appropriate action to modify their system should they encounter data content or reporting problems.
- Flexibility in achieving meaningful use - Rather than develop the program with a simplistic “pass/fail” structure, we recommend that physicians be given a “report” on their meaningful use achievement and sufficient time to restructure/modify their systems and submit corrected data to achieve full meaningful use during a particular reporting period.
 - 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 demonstration. This would be especially important for the initial phases of the program and could be verified through an audit process. The development of a complicated and time-consuming process for practices to prove that they meet the incentive qualifications will result in fewer organizations transitioning to EHRs.
 - Simplified physician attestation – The process for physicians to demonstrate that they have achieved meaningful use should be simple and flexible enough so that physicians in all types and sizes of practice can attest this to the government. We strongly encourage that self-attestation be the primary attestation approach adopted. In addition, much like physician use of the data registries for PQRI reporting, third party attestation should also be considered.
 - Closely monitor the EHR marketplace – Section 3007 (a) of the ARRA legislation requires that the “National Coordinator shall support the development and routine updating of qualified electronic health record technology (as defined in section 3000) consistent with subsections (b) and (c) and make available such qualified electronic health record technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the marketplace.” We encourage the close monitoring of the EHR marketplace to ensure that appropriate and cost-efficient products are being offered to physician practices, especially small practices with limited financial resources. We also encourage the early recognition of marketplace failures and subsequent deployment of an appropriate low-cost alternative EHR software product and supporting structure .
 - Simplify the reporting process-- Quality reporting is a central element of meaningful use. Allowing practices of varying sophistication the ability to report the quality data utilizing various methodologies (ie, claims-based, data registries, and summary clinical data transmitted directly via the EHR) would ensure that as broad a group of practices as possible would have the ability to move forward with adoption of HIT, successfully report quality measures and qualify for the incentives. In addition, it is critical that this

reporting requirement take into account current reporting programs to avoid duplicative efforts.

- Institute a process to test physician reporting systems -- Many practices participating in the Physicians Quality Reporting Initiative program discovered after the program had ended for the year that they did not qualify for the incentive payments. In order to avoid physician practices experiencing a similar problem for the ARRA incentive program, we recommend that the government develop a process where physician practices could submit their software specifications, test their quality data reporting methodology and receive timely and actionable feedback regarding their ability to qualify for the incentive payments.
- Recognize time constraints –We contend that the 2011 start date for the incentive program precludes the development and deployment of significant additions to the criteria required for certification. Since the process of software identification, acquisition, implementation and testing typically takes one to two years, the consequence of adding requirements that are not currently required in CCHIT-certified systems will most likely be significantly slowed software development. Thus, many physicians would lack the opportunity to qualify for the incentives until well after 2011. Meaningful use should be defined in a way that allows physician practices and their EHR vendor partners to meet the incentive requirements with reasonable effort and without undue burden.
- Closely monitor provider and vendor 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 to meet this challenge and quickly identify barriers to the successful adoption of HIT and solutions to those barriers.

In addition to monitoring the provider sector of the industry, we strongly encourage HHS to oversee the vendor community to ensure that they are able to meet the demands of the market. If the ARRA incentive program is viewed in a positive manner by the majority of physicians, there will be a significant surge in the number of practices seeking to purchase and install EHRs. This raises the specter of potentially lengthy installation queues, hasty installations that result in sub-optimum clinical performance, insufficient maintenance support, slowed upgrades, delayed customization, and the possibility of unfair business practices and inflated pricing. We urge HHS to aggressively scrutinize the EHR vendor sector, establishing toll-free telephone numbers and a Website allowing physician practices and others to report problems, issues, and unfair business practices.

- Physician practice outreach – The success of the ARRA incentive program will rely in part on effective outreach to the physician practice community. Timelines, definitions, program modifications, updates and the application processes all must be communicated directly to the potential incentive recipients. We recommend that HHS develop a multi-pronged communication process that includes, but is not limited to:
 - An easy-to-navigate Website with a comprehensive FAQ section.
 - Toll-free telephone numbers to provide accurate information.

- Regularly-scheduled “open door” Webinars to provide updates and address participant questions.
- Participation by HHS officials at industry conferences and forums.
- Direct outreach to provider trade associations.

In conclusion, MGMA strongly supports the objectives of the ARRA incentive programs to stimulate adoption of HIT. However, in order to maximize the success of the program, we believe that an appropriate definition of meaningful use and program logistics must be developed. Should the qualifications for participation in these incentive programs be overly stringent or the process too onerous, the government runs the risk of excluding a large percentage of physician practices from participation.

This is a historic opportunity to reform and revitalize the nation’s health care system. However, considerable work must be accomplished in order to make effective HIT widely available. We look forward to working with HHS to facilitate the physician practice transition to EHRs and make the promise of improving the nation’s health care system through technology a reality.

Sincerely,

A handwritten signature in black ink, appearing to read "William F. Jessee".

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