AMA AMERICAN MEDICAL ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

August 12, 2009

David Blumenthal, MD, MPP
National Coordinator for Health
Information Technology
Department of Health and Human Services
Office of the National Coordinator for
Health Information Technology
200 Independence Avenue, SW, Suite 729D
Washington, DC 20201

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Bldg.
200 Independence Avenue, SW
Washington, DC 20201

Re: Health IT Policy Committee's July 16, 2009, Proposed Meaningful Use Matrix and 2011 and 2013 EHR Measures

Dear Dr. Blumenthal and Ms. Frizzera:

The American Medical Association (AMA) is deeply supportive of efforts to incorporate electronic health records (EHRs) into physicians practices to improve quality of care delivery as well as enhance practice efficiencies. The purpose of this letter is to provide you with ongoing feedback on the objectives and measures adopted by the Health IT Policy Committee on July 16, 2009, which cover proposed criteria that physicians and other health care providers would have to meet as meaningful users of EHRs in order to receive Medicare incentives starting in 2011.

On June 26, 2009, the AMA along with 82 specialty and state medical societies submitted to the Office of the National Coordinator (ONC) our proposal for an achievable and predictable pathway toward meaningful use of EHRs, including a set of program specifications for meeting the 2011 incentive payment timeframe and beyond. Our proposal, which we developed after months of considerable, thoughtful deliberations, enables eligible physicians in all sizes of practices and specialties to take advantage of the financial incentives authorized by the American Recovery and Reinvestment Act (ARRA). Our recommendation to the ONC, which is to ease into EHR measure reporting during the initial adoption and use phase, is directly in line with the law, given that ARRA recommends reporting requirements to progress over time. We must keep in mind that the capability to report each measure will require significant EHR use, programming, training, and

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information exchange. **However, many of the proposed measures and objectives outlined by ONC and the Health IT Policy Committee are too aggressive and can not be feasibly met by the deadlines outlined in ONC's matrix.** Below, we have detailed our overall concerns and have attached a redlined version of the matrix that includes our specific comments on the proposed requirements for 2011 and 2013.

General Concerns

Given that so much of the EHR functionality, that will be required to support the proposed objectives and measures is not yet in place, the current capability of EHRs must be examined and considered for the 2011 objectives. Our June 26, 2009 proposal recognizes such prerequisites, consider factors in critical interrelated pieces, and identifies the need for "checkpoints" before moving from one level of meaningful user criteria to the next. This check point assures industry readiness, acknowledges the need for active participation among all relevant health care partners in health information exchanges, and the capacity of the system to meet desired EHR objectives and goals. **We therefore continue to strongly recommend that prior to moving from the use of one set of requirements to a more stringent set, the specifications for accomplishing them must be incorporated and available in at least 90 percent of EHRs in the marketplace (a column should be added to the matrix indicating when a functionality meets this threshold). Furthermore, physician as well as all industry stakeholder readiness must be considered part of this checkpoint process. It is also important that the matrix acknowledge that not all of the requirements may be relevant to a particular physician, in which case the physician should be able to demonstrate meaningful use through the remaining pertinent specifications.**

Concerns with Proposed Objectives

As indicated above, the AMA is concerned that physician practices cannot meet the ONC's proposed objectives on their own. Practices are reliant on a number of other entities in the health care system to make decisions that can have a significant impact on business operations and often require financial investment in order to achieve these objectives. Often those entities are significantly larger—such as hospital systems, regional or national laboratories, pharmacy chains, and health plans—and practices, most of which are small businesses, have little market leverage to impact these larger entities. The federal government, through the Centers for Medicare & Medicaid Services (CMS), has a unique ability to move not only physician practices, but almost every organization in the nation's health system, towards a common goal of widespread use of EHRs and electronic health information exchange. **The AMA looks forward to working with ONC and CMS to encourage all relevant parties in the entire health system to work together in moving towards efficient and practice information exchange for the purposes of higher value and quality of care.**

We do not agree with the Committee's proposal to include measures that go beyond the scope of ARRA's meaningful use requirements such as references to administrative functions like checking insurance eligibility, the disqualification of eligible physicians from meaningful use incentives based on alleged HIPAA privacy and security investigations and/or violations, and the proposed requirements surrounding personal health records (PHRs). **(Please review more detailed comments in the attached red-lined matrix.)**

Concerns with ONC's Proposed Measures

In reviewing the proposed measures outlined in the matrix, we have determined that the majority of the July 16, 2009, HIT Policy Committee's proposed measures for data collection and reporting have not undergone adequate testing, analysis, and fail to consider the following dependencies: the availability of the required EHR functionalities and standards; the readiness of several others in the health care spectrum to securely exchange data with physicians; physicians having real-time access to medical information and tools; and the ability of individual physicians to incorporate these technologies into their existing workflow.

It is important to recognize that reporting quality measures through EHRs is neither easy nor is it something that can be quickly operationalized. CMS' experience with the Physician Quality Reporting Initiative (PQRI) highlights the complexities associated with measurement reporting. In its FY2010 proposed rule, CMS indicates its desire to implement an EHR reporting option for the 2010 PQRI. However, this is contingent on whether the agency successfully completes its 2009 EHR data submission testing process and a determination, based on that testing process, that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. It is clear that CMS is struggling with this issue as they are still unsure whether they can permanently add an EHR reporting option to PQRI for 2010. In addition, this would only be for 10 measures of the 176 they are proposing for 2010.

To ensure providers are successful in submitting quality reporting information to CMS through an EHR, the CMS system must be able to handle such submissions. This depends largely on the agency's ability to modernize their systems so that they can receive data from multiple providers and through their EHR systems. While EHR reporting would make it easier for some eligible professionals to report on more complex measures, it is critical that the agency's system can handle such submissions, and correctly calculate the submissions to make determinations regarding successful participation.

We agree that a predictable pathway for measure reporting from EHRs should be laid out so that providers, EHR vendors, and others can begin to plan for increased complexity of measures. We also agree that to assess the care of populations based on data from EHRs, thought must be given on how to query and report on outcomes. At this point in time, however, we believe we have a tremendous opportunity to advance the use of EHRs by

health care providers and to advance the availability of measurement data to physicians within their practices—data that are actionable in caring for patients day-to-day and facilitate quality improvement. **In order to ensure success beginning in 2011 with the meaningful use of EHRs we recommend the following:**

1) Draw, initially at least, from measures in use in a national program or large demonstration project (e.g., measures selected for EHRs reporting for CMS PQRI and in the CMS EHR demonstration). Physicians and EHR vendors have begun to work on these measures as well as others who provide the EHR specifications;

2) Include important process measures that matter—those measures with a demonstrated link to outcomes, and identify a predictable pathway to move from process measures toward outcome measures;

3) Include a broad set of measures applicable for all specialties. For example, the measurement portfolio developed by the AMA-convened Physician Consortium for Performance Improvement® (PCPI) is applicable to many specialties. This portfolio provides an opportunity for broad participation and continues to be expanded;

4) Progressively expand the set of measures as the required functionalities and code sets are confirmed to be present in most EHRs in use (e.g., lab values automatically imported into EHRs prior to measure based on lab values); and

5) Include measures as they are tested and are demonstrated to be ready for integration into EHRs. The AMA Cardio-HIT project is an example where coronary artery disease and heart failure measures and the associated EHRs specifications have been tested within 5 different EHR products and the data were sent successfully to a centralized warehouse for analysis.

We appreciate the opportunity to share our concerns with you and welcome the opportunity to discuss any of the concerns raised in our letter and attachment. Should you have questions about these comments, they may be directed to Mari Savickis at mari.savickis@ama-assn.org or 202-789-7414.

Sincerely,

Michael D. Maves, MD, MBA

Attachment