hivma
hiv medicine association

1300 Wilson Boulevard Suite 300 / Arlington, VA 22209
703-299-1215 / f 703-299-8766 / info@hivma.org / www.hivma.org

March 11, 2010

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

RE: Comments on Proposed Rule [Docket No. CMS–0033–P]: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; RIN 0938–AP78

Dear Acting Administrator Frizzera:

The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) appreciates the opportunity to offer comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule on "meaningful use" of electronic health records (EHRs) under the Medicare and Medicaid EHR Incentive Programs. I am offering these comments on behalf of our more than 3,700 clinician and scientist members that are devoted to the field of HIV medicine and that provide HIV care and treatment across the U.S.

The proposed rule is important to HIV medicine, considering that 40% of our HIV patients rely on Medicaid and nearly 20% rely on Medicare programs for their health care coverage. As proponents of the use of health information technology to improve the quality and coordination of HIV medical care and control costs, we urge the administration to simplify the meaningful use criteria and incentive payment qualifying requirements in order to ensure the success of the program among HIV providers. Unless significant changes are made and timelines reexamined, many HIV safety net medical providers will likely have difficulty meeting the proposed standards, making them ineligible for this important funding, and subjecting them to Medicare reimbursement rate penalties for noncompliance. In developing the final rule, we urge you to consider the following recommendations:

1) As presently structured, the EHR incentive program will favor larger, better-funded practices and early adopters. We are concerned about the challenges small and medium sized practices with limited IT and data management staff resources will have in meeting the new standards and qualifying for incentive payments. Many HIV providers that serve large numbers of Medicaid patients and underinsured and

uninsured patients are already strained by increasingly tight budgets and excessive administrative burdens. They will face serious hurdles qualifying for incentive payments if requirements are overly onerous and complex. We understand that operational support for selection, adoption, upgrading and maintenance of health IT systems will eventually be offered by planned regional extension centers once they are up and running. However, such assistance may not be available in time for providers to obtain the support necessary for them to qualify for the incentive program.

Therefore, we are concerned that the incentive program will favor larger and better funded practices that have already transitioned to EHRs or are in the process of doing so. Providers at lower stages of EHR adoption who could benefit most from adopting EHR systems and from the incentive payments will be left behind, which will only exacerbate existing health disparities.

Even academic medical centers that serve as Centers of Excellence for HIV care and have adopted EHR face challenges. The available EHR products that are designed for stand-alone clinical practices and managed care settings do not provide the functions required in multi-center academic medical practices. A primary function of university-based medical centers is to educate medical providers, and EHRs must be re-designed to accommodate multiple providers managing the care of one patient as is standard practice at academic medical centers where faculty supervise trainees. Institutional systems will need to be re-designed to integrate standard EHRs, which will require the ability to perform more complex functions such as pharmacy order-entry, transitions of care between services and hospitals, security and privacy, and providing patients and families with electronic access to EHR data.

For the Medicaid EHR incentive program, we strongly support CMS's proposal to provide incentive payments to Medicaid practices in the first year of the program for adopting, implementing, or upgrading (rather than reporting on meaningful use of) certified EHRs. This will improve the ability of Medicaid providers to participate in and benefit from the program. We are also pleased that CMS did not propose eventual reimbursement rate penalties for Medicaid providers who are unable to comply with EHR meaningful use criteria within a specified timeframe. It will be crucial to target under-resourced safety net providers, including HIV medical providers, for technical and financial assistance for EHR adoption and use.

2) Reporting requirements and data systems must be streamlined across federal programs to eliminate redundancy and maximize efficiencies with limited program, IT and data management resources. Many HIV providers rely on funding from multiple federal agencies in addition to Medicare and Medicaid to provide HIV care and treatment to their patients. EHR offer an important tool for improving patient care and outcomes while also reducing overall system costs. However, if providers are required to report data in varying formats to federal agencies and maintain parallel data management systems for different federal programs, administrative costs and burden will continue to grow rather than decrease. We strongly urge you to ensure uniformity in data reporting across federal programs whenever feasible.

3) The proposed requirements for demonstrating meaningful use of EHRs may be overly burdensome and needlessly complex for some practices, which could discourage physician participation in the program, especially among safety net clinicians. We urge simplification of the criteria as well as flexibility in reporting

requirements. Rather than requiring reporting on all of the 24 proposed meaningful use objectives, we strongly support the HIT Policy Committee's February 17, 2010 recommendation to ease some of the standards to allow providers to defer a certain portion of meaningful use objectives without jeopardizing their incentive payments. Specifically, this change would allow providers to defer a certain number of objectives from 4 of the 5 meaningful use domains: 3 objectives from the quality/efficiency domain, 1 objective from the patient engagement domain, 1 from the care coordination domain, 1 from the population health domain, and 0 from the privacy and security domain. However, a list of 7 objectives would remain mandatory. We support this proposal and urge its adoption.

4) Clinical quality measures to be reported must include those that are applicable to the patients and conditions HIV physicians treat. It s critically important that the quality measurement reporting aspect of meaningful use be determined on a specialty-by-specialty basis which takes into account the universe of clinically relevant and meaningful quality measures currently available for each specialty. The proposed rule arbitrarily limits the specialty measures on which providers can report to 15 selected specialty groups – excluding infectious diseases and quality measures for management of HIV infection. We understand that CMS expects to expand the set of clinical quality measures in future years, but even the clinical quality measures proposed for 2013 and beyond (pp. 1900–1) fail to include HIV and infectious diseases measures. While some primary care quality measures may also be clinically relevant for HIV care, we see no reason not to include among the specialty groups some of the measures on which physicians may already report under the 2010 PQRI program, including the eight HIV-specific measures:

159. HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
160. HIV/AIDS: *Pneumocystis jirovecii* Pneumonia (PCP) Prophylaxis
161. HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
162. HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy
205. HIV/AIDS: Sexually Transmitted Diseases – Chlamydia and Gonorrhea Screenings
206. HIV/AIDS: Screening for High Risk Sexual Behaviors
207. HIV/AIDS: Screening for Injection Drug Use
208. HIV/AIDS: Sexually Transmitted Diseases – Syphilis Screening

5) Clinical quality measures focused on preventive care should be expanded to include HIV and STD screening: Proposed clinical quality measures focused on preventive care include influenza immunization rates, smoking cessation counseling, BMI screening and follow-up, and aspirin therapy. We urge the inclusion of HIV testing, and screening for hepatitis C and sexually transmitted infections consistent with recommendations of the Centers for Disease Control and Prevention (CDC). In 2006, the CDC released revised recommendations for HIV testing, advising that all patients age 13-64 in healthcare related settings receive routine testing for HIV. The inclusion of HIV testing and reporting in the proposed preventive service quality measures would help to facilitate and monitor efforts to implement the 2006 CDC recommendations for HIV screening. Inclusion of HIV and STD screening recommendations in the preventive services quality

measures could also facilitate more accurate data collection to improve state and federal public health surveillance.

6) The capabilities and functionalities of EHR systems should support coordination of care through the patient-centered medical home model, which requires reform of reimbursement incentives. HIV providers have been pioneers in the development of the patient-centered medical home model of care, and we recognize the value of EHRs as a tool to enable the improvements in quality, safety, efficiency, effectiveness and access that the medical home model is designed to deliver. However, without reimbursement to support care coordination activities, we are concerned that EHR use and design will continue to overemphasize documentation for billing purposes, rather than for the improvement of patient care and coordination.[1]

7) Meaningful use objectives 22-24 that rely on patient level information being transferred between entities (laboratories to office, hospital to office, office to office) will be problematic in the absence of a clear legal and policy framework dictating the exchange of clinical data under the HIPAA.[2] Effective HIV care and treatment depends heavily on laboratory and other screenings, and test results comprise a large share of medical record data for HIV patients. Provider ability to meet these particular objectives will require clarification and updating of HIPAA rules and state-specific medical release and laboratory licensing laws. Significant work must first be done to strengthen and facilitate the implementation of electronic laboratory and other interfaces before these objectives can realistically be met. One recommendation is for patients entering a practice for the first time to sign an authorization to have their data securely sent and used for such purposes.

Thank you for your consideration of our views. For further information, or if we can be of any assistance, please contact us through HIVMA Executive Director Andrea Weddle (aweddle@hivma.org).

Sincerely,

Kathleen Squires, MD
Chair-Elect, HIV Medicine Association

[1] A. S. O'Malley, J. M. Grossman, G. R. Cohen et al., "Are Electronic Medical Records Helpful for Care Coordination? Experiences of Physician Practices," Journal of General Internal Medicine, published online Dec. 29, 2009.

[2] "Electronic release of clinical laboratory results: a review of State and Federal policy," California Healthcare Foundation, January, 2010.