



March 12, 2010

Ms. Charlene M. Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Attn. CMS-0033-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Dear Administrator Frizzera:

I am writing on behalf of Arizona Health-e Connection (AzHeC). Established in January 2007, AzHeC is a not-for-profit organization whose mission is to lead Arizona's establishment of health information exchange (HIE) and adoption of health information technology (HIT). Initially, AzHeC was a state-led program called upon by the Governor to comprehensively review issues and develop recommendations. Having accomplished that phase of our mission, we are now directed by a very diverse, private-public partnership to refine those recommendations and facilitate implementation.

This letter's purpose is to offer comments on the regulations defining Meaningful Use (CMS-0033-P). AzHeC commends the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology for the tremendous work and thought that contributed to the crafting of these proposed regulations.

AzHeC is specifically recommending modifications or suggestions in thirteen areas, though remains sympathetic to many of the additional comments provided by organizations such as the American Academy of Family Physicians (AAFP), the Arizona Hospital and Healthcare Association (AzHHA), The Healthcare Information and Management Systems Society (HIMSS), and the College of Healthcare Information Management Executives (CHIME).

AzHeC's recommended modifications are as follow:

- 1. Narrow the Hospital-Based Eligible Professional Definition.** A large number of providers, according to the proposed rule, will not qualify for incentive payments due to their being included in the definition of hospital-based eligible professionals, in spite of their primary use of ambulatory electronic health records, and smaller secondary, it at all, use of the hospital in-patient electronic health record system. We understand CMS' own estimation is that one-third

of otherwise eligible professionals (according to the original ARRA language) would be disqualified for incentive payments under this rule. AzHeC recommends that CMS adopts a narrower definition of hospital-based eligible professional, allowing more professionals to qualify for incentive programs outside of this definition, as originally intended by ARRA and Congress. We recommend specifically that a hospital-based eligible professional should be defined as one who provides 90% of their services (calculated by number of encounters) in a hospital setting and utilizes the hospital's in-patient electronic health record system in that setting.

- 2. Allow Flexibility in Meeting Meaningful Use Criteria.** This mirrors recommendation #12 made by the HIT Policy Committee in its March 4, 2010 letter to Dr. David Blumenthal. The otherwise "all or nothing" proposed rule is deemed to be extremely difficult to attain in Stage 1. Though many are also recommending lowered percentage requirements for criteria, this flexibility may be better attained by selecting "mandatory" and "optional" criteria for Stage 1, requiring a combination of all mandatory criteria and a number of optional criteria (of the choice of the Eligible Professional or Eligible Hospital), which can be tailored to the system, type of practice, level of familiarity with electronic health record systems, etc.
- 3. Establish Reasonable Timing of NPRM (definition) Versus Implementation for Stages 2 and 3.** Moving practices and hospitals from paper to Meaningful Use requires supply and demand sides of the market to mature accordingly, providing a robust and ready population of users of electronic health records, while also allowing the innovators and suppliers of the technologies the time needed to meet the growing and maturing demands. In the past several years, expectations were being set and monitored through a system of standards development and selection – providing targets for vendors – while the certification process and associated roadmaps allowed vendors to effectively plan to have systems certified and in the marketplace in a reasonable timeframe. This timeframe was approximately 18 months. AzHeC recommends the NPRM for Stage 2 be available by the end of 2010 and the final rule by April 2011, that the NPRM for Stage 3 be available by the end of 2012 and the final rule by April 2013 at the latest. Additionally, the stages should be linked, so that one stage sets a clear and practical pathway to the next stage.
- 4. Establish Safe Harbor for Good Faith Attestation by Eligible Professionals (EPs) and Eligible Hospitals (EHs) of Meaningful Use.** Many EPs and EHs have expressed concern with meeting all of the specific percentage requirements for Meaningful Use criteria and the stiff penalties if missing a single percentage point qualifies the provider as attempting to "defraud" the federal government. This concern can be lessened by allowing flexibility in meeting Meaningful Use criteria, but AzHeC also recommends that providers only be required to pay back the incentive money received for a given year if it is determined they did not actually meet the criteria, if the provider has made a good faith attestation of having achieved Meaningful Use. Additionally, providers should not be held responsible if an electronic health record system certified under federal government-approved certification processes is unable to deliver functionality for which

it was certified, when installed and used. Such responsibility and liability should fall therefore to the electronic health record system vendor.

5. **Separate e-Prescribing Clinical and Efficiency Alerts.** AzHeC recommends that CMS separate the required alerts by their purposes. Drug-Drug, Drug-Allergy and Drug-Condition alerts are for the purpose of ensuring patient safety. Drug-Formulary alerts are for the purpose of establishing financial efficiencies and cost-savings. Both are important, but these differences should be recognized and reflected in the rules.
6. **Lower the e-Prescribing Required Percentage to 50%.** AzHeC has been leading a statewide e-prescribing initiative for over two years, and recognizes there are many existing challenges in the e-prescribing system and a comprehensive troubleshooting scheme needs to be implemented within each state. Issues include community pharmacies that have not yet adopted e-prescribing due to its transaction costs, thus physicians whose patients utilize such pharmacies are unable to e-prescribe. The current prohibition on e-prescribing of controlled substances also creates inefficiencies, use of parallel paper prescribing and e-prescribing processes in the same practice or hospital, which has prevented many EPs from adopting e-prescribing. AzHeC recommends lowering the e-prescribing required percentage to no more than 50% for Stage 1, which is equivalent to other CMS incentive requirements for e-prescribing incentives.
7. **Establish Financial Incentives for Pharmacies to Invest and Utilize e-Prescribing.** As mentioned above, many community pharmacies have not invested in e-prescribing technology and do not use it due to the cost of e-prescribing transactions. AzHeC recognizes that the transaction costs are lowering as the scale of e-prescribing increases, but believes that incentives on “both ends” of the e-prescribing equation will create an incentive for providers and pharmacies to work together to e-prescribe in their communities.
8. **Allow e-Prescribing of Controlled Substances; Establish Reasonable yet Secure Processes for such e-Prescribing.** AzHeC urges CMS to work with the Obama Administration and the Drug Enforcement Agency to speed up the pilot programs for e-prescribing of controlled substances in order to more rapidly establish reasonable yet secure processes for such e-prescribing.
9. **Allow Medicare EPs to Utilize Incentive Payments for Preparation, Adoption and Implementation of, and Training on Electronic Health Record Systems in the same way as Medicaid EPs.** Though ARRA specifically mentioned this allowance for Medicaid, it was silent on Medicare. The reason for this lack of parity is unclear, but it will clearly result in maintaining and not removing the major barrier to electronic health record adoption of capital investment experienced by Medicare EPs.
10. **Allow Non-EPs to Perform Some Tasks Required by EPs for Meaningful Use, with EPs Ultimately Responsible for the Task Completion.** This will encourage team-based provision of

care and care coordination, which is critical for addressing the current health care, and specifically primary care, professional shortage as well as health care costs.

- 11. Establish Financial Programs for State and Local Public Health Departments to Invest in Health Information Technology.** As AzHeC has explored the needs of public health programs within Arizona and other states, it has become clear that especially in the face of decreasing budgets, public health and other departments are often unable to make the required investments in health information technology programs (e.g, immunization registries, advance directive registries, electronic health record systems for state behavioral health programs), that will facilitate the sharing of health information required by EPs and EHs under Meaningful Use. AzHeC strongly encourages CMS to recognize this potentially “weak link” in the chain of exchanging information for public health purposes and to utilize existing funds to establish grant programs to address this need.
- 12. Recognize and Address the Need for Patient Identification or Authorization Mechanisms.** As the NPRM recognizes, electronic health record systems must internally establish a method for tracking unique patients, a requirement for calculating any of the percentage requirements (numerator/denominator) for clinical quality and other Meaningful Use criteria. There is a growing recognition that patient matching systems such as enterprise master patient indices have error rates, and yet certain forms of patient identification also raise privacy concerns (e.g., national patient identifier). AzHeC urges CMS to work with HHS and specifically ONC to identify methods of patient authorization or identification that will reduce record-matching errors, while maintaining privacy and security.
- 13. Maintain Staging of HIE Requirement (no modification required).** AzHeC applauds the proposed staging of HIE functionality, beginning with a more attainable level of exchange in Stage 1, while accelerating the exchange requirements for Stage 2 and Stage 3.

AzHeC thanks CMS for the opportunity to provide these comments during this period and welcomes any engagement regarding the justification for any of these comments.

Sincerely,



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Arizona Health-e Connection