New York State Department of Health
Medicaid Incentive Payment System (MIPS)
External Stakeholder Feedback

New York Chapter of the American College of Physicians

(NYACP)

April 6, 2010 | 11:00 a.m. – 1:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York Chapter of the American College of Physicians (NYACP). The NYACP is a membership organization dedicated to advancing the specialty of Internal Medicine in New York State. Among the NYACP's primary functions is assisting members and patients through advocacy, education, networking, and communication. In attendance were:

New York State Department of Health – Office of Health Insurance Programs

James J. Figge, M.D., M.B.A., Chair Medical Director
Phyllis Johnson, HIT Policy Coordinator

New York State Department of Health – Office of Health Information Technology Transformation (OHITT)

Roberto Martinez, MD, Medical Director

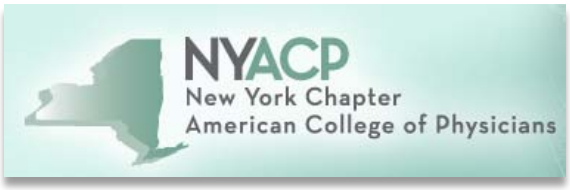
New York Chapter of the American College of Physicians

Louis Capponi, MD, Chapter Member and Practicing Internist
Jennifer Keefer, M.D., 3rd-Year Resident - Internal Medicine
Linda A. Lambert, CAE, Executive Director
Babette M. Peach, Director of Advocacy and Communications

New York State Technology Enterprise Corporation (Program Consultants)

Donna O'Leary, PMP, Program Consultant

New York Chapter of the American College of Physicians – Overview



The mission of the New York Chapter of the American College of Physicians (NYACP) is to advance the specialty of Internal Medicine in New York State by assisting members and patients through advocacy, education, networking, and communication. Among the goals of the NYACP is to:

- Advocate responsible positions on individual health and on public policy relating to health and on public policy relating to healthcare for the benefit of the public, our patients, the medical profession and our members;
- Serve the professional needs of the membership, support healthy lives, improve the practice environment for physicians, and advance internal medicine as a career;
- Promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and to the public;
- Recognize excellence and distinguished contributions to internal medicine; and
- Unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession.

The following is a summary of statements regarding the Medicaid Incentive Payment System by Louis Capponi, MD.

Comments

I've been a practicing general internist in the state for the past sixteen years, and a member of the college for my entire medical career. In addition to my current role as the co-chair of the Health Information Technology Steering Committee of the New York ACP, I've spent the last six years immersed in health information technology through my position as the chief medical informatics officer for the New York City Health and Hospitals Corporation. Through both of these activities I've become very familiar with health information technology.

The New York Chapter of the American College of Physicians represents twelve thousand internal medicine doctors in New York State. The chapter focuses on disseminating information and fostering discussing on scientific, economic, and social issues related to the practice of internal medicine. The chapter has a long history of advocating on behalf of physicians, and supporting excellence in patient

care. The college also has a long history of credibility with its members. They turn to us as the premier medical education resource, and value the guidance offered relating to advocacy and to social and economic issues in medicine. The New York chapter shares many goals with our parent organization, the American College of Physicians, including the promotion and conduct of research to enhance quality of practice, ongoing education of internists, and promotion of careers in internal medicine to physician trainees. The chapter recognizes excellence and distinguished contributions to internal medicine by individuals and organizations, and advocates for personal and public health practices to support wellness.

New Challenges and Opportunities in Health Care

During the next decade, clinical medicine will experience a transformation on a scale not imaginable in previous history. Rapid advances in clinical genetics will impact care with the same order of magnitude that the introduction of antibiotics and immunizations did in the last millennium. The clinical decisions we make will be informed by the widespread availability of genotyping and high-dimensional genetic statistics. Such technologies will not only allow for better population-based screening efforts but will also enable a personalized approached to care, an approach based on the person's genome and epi-genome to direct therapeutic decisions. We will see the expansion of microbial cancer and other databases, which will allow more precise diagnoses and more targeted therapies. As these technologies develop, physicians will require information systems which are nimble enough to take advantage of this evolving field. Sophisticated terminology services will likely be necessary, as will access to external supercomputing resources, and complex decision-support schemas. The New York ACP wants our members to be ready for such innovations, and we strongly believe that health information technology is a prerequisite to leverage scientific advances of tomorrow.

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> Louis Capponi, MD

In addition to the clinical imperatives, the revolution in healthcare will focus on patient choice and consumerism. More than ever, physicians will need real-time, clinically relevant information, not only to improve safety, lower costs, and improve outcomes, but also to increase patient satisfaction. We will need tools to interact with patients virtually, for simple issues, and be able to spend more time with patients face-to-face for complex ones. We'll need systems to support asynchronous communication for routine matters, and faster access for urgent ones. Basic office

functions, though necessary, are no longer adequate to sustain a practice in today's healthcare economy. Advanced functions are needed to automate simple activities, execute complex protocols, and monitor multistep processes through functionality known in other fields as business process management tools. Such tools examine new and existing data on a patient, or a population of patients, in real time, and can apply protocols over an extended period of time. As the patient's condition or status changes, a new rule or protocol can be activated with the aim of guiding care to the expected outcome. Workflow can be applied to clinical and nonclinical aspects of care. For example, a patient on an anti-psychotic might be expected to have a neurological check for side effects every six months. However, if the patient's exam is abnormal, a reassessment may be needed in an earlier period. If the patient has not been seen within the expected time frame, the workflow engine could alert a care coordinator to reach out to the patient and make sure he or she does not fall through the cracks.

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We applaud and support the efforts of our state and the federal governments with regard to HIT. Notwithstanding this great potential, the New York ACP is also familiar with the huge challenges faced by physicians, especially those in small and solo practices, during the early stage of technology adoption. And it is with this perspective that we submit our comments to CMS for the American Recovery and Reinvestment Act incentive program, and also appreciate the opportunity to speak with you and convey that perspective today.

Meaningful Use – More Time is Required

The New York Chapter of the American College of Physicians believes that the time frame for adoption of technology is unrealistic under this program. The final rule requires meaningful use by the last quarter of FY 2011, which is now just 18 months away. In order for a technology rollout to be successful, the bar should initially be set at a modest level. This approach will encourage adoption and provide the important positive initial experiences so vital to success. Once a practice gets comfortable with HIT, my experience is that they rarely revert back to a paper process. However, if the initial experience is too disruptive, it can result in a failed implementation, and the consequence of that is a lot of future resistance.

Successful HIT adoption requires adequate time for practices to redesign workflow and adjust to the new technology. At the same time, the practice must safely see as many patients as possible. Most physicians do not have the technology skills needed to electronically run their offices. Some do not even bill electronically themselves, let alone have the capacity to install and maintain the complex EHR system. Even with

stimulus dollars, practices with limited financial and technology resources will not be able to undergo an abrupt transition. Physicians deliver care on a daily basis, and along with nurses are the ultimate and principal users of technology in healthcare. Our membership ranges from the solo practice to a large multi-specialty group. And physicians are in a unique position to provide and comment and provide direction. We seek to create the best environment and to maximize adoption of health information technology to deliver the highest quality of care. Yet, if implementation of meaningful use proceeds at the pace currently envisioned, there will not be time to benefit from such experience and participation, and physician satisfaction and adoption, and the overall impact of the implementations, will suffer.

Small Practices – Bigger Challenges

It's important to recognize that in small practices, the physician is also in essence the chief technology officer. If the transition to meaningful use is too demanding, many physicians will choose not to adopt technology, or may consider early retirement, unfortunately exacerbating the shortage of physicians, particularly in primary care. To complicate matters we believe that the vendor community lacks the human capital necessary to respond to the increased demand for software and hardware installation. The low supply of skilled technicians and other workers is having an unintended consequence already being felt by physicians, in the form of competition for vendor attention. We believe increased demand will provide an economic opportunity for vendors in the face of limited supply. Larger practices will have greater response from vendors, and the least profitable small practices will be the last on the vendor's list to implement, and the least likely to get to meaningful use in time. We strongly support and are encouraged with the efforts of NYeC, the PCIP and the P Collaborative and others, who can play an important role in implementation, and particularly if those programs don't burden practices with additional conditions of participation beyond those of meaningful use.

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The New York ACP believes that setting compliance thresholds is not reasonable or necessary. And a number of the measures require some manual activity in order to submit the meaningful use measure that's articulated, at least in the current rule. For example, one of the measures requires the physicians to be commenting or reporting on their electronic prescribing percentage rate. But in order to do that, you have to manually count manual prescriptions. And so the burden is on the practice to actually have a separate process to track a denominator in a setting where we're

really trying to encourage electronic transition and electronic reporting. So, we think that those additional burdens on the providers will actually become impediments to adoption. We want to avoid those types of indicators, both as they relate to the meaningful-use criteria and as they relate to quality metrics. Practices should not have the burden of tracking the denominators manually, or tracking any indicators manually. Instead, the indicators should be chosen which are completely electronic and can be generated without any additional efforts.

Conceptually, meaningful use is an electronic version of the principals of the patient-centered medical home. Physicians know from experiences with those practices which have transitioned to the medical-home model, that it is an expensive, labor-intensive, and complex transformation, and beyond the reach of most practices without appropriate funding of extra services. Given the already poor reimbursement for primary care, appropriate funding is essential to sustain those efforts. The improvements in quality care that all stakeholders seek to achieve for patients will only occur when we reach critical mass with as many physicians and hospitals as possible on line. When groups of physicians are dissuaded by standards that are too difficult to achieve, society misses out on the opportunity to improve care. Facilitating maximum participation by all practicing physicians will only strengthen success.

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The Medicaid Gambit

While the ARRA program includes Medicaid patients, there remain significant financial burdens and barriers to most practices in New York State that care for Medicaid populations. We applaud the efforts of the state to provide enhanced Medicaid reimbursement under the patient-centered medical homes model, and in other initiatives for diabetes and asthma care. However, the gap between Medicaid and other payers remains high, with New York State having ranked forty-seventh lowest among all states with regard to Medicaid fee-for-service payments in the past. Within the last two years the state has committed additional resources to invest in Medicaid fee-for-service rate increases. But those investments have only gotten primary care fees to approximately sixty percent of the Medicaid fees. There will be

another three-year gap until the federal requirement for states to pay a hundred percent of Medicare rates kicks in, long after the ARRA incentive program became available. Medicaid patients continue to be in need of additional primary care and access.

Certainly, ARRA incentives for Medicaid providers are attractive. However, the threshold for qualifying under Medicaid requires that thirty percent of the total practice is Medicaid. That level is too high in New York State, because of its historic underpayment of Medicaid fees. Only eleven percent of New York State physicians would meet this threshold, and therefore, only a small percentage may be able to get funding through this program under Medicaid. The New York Chapter of the American College of Physicians believes that some of the meaningful-use criteria proposed by CMS will not result in significant care improvements.

Standardization is Key

> "NYACP recommends to CMS that certification require EMR vendors to provide standard interconnectivity interfaces as part of the basic package, once those are defined."
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Electronic copies of records for patients, as currently defined in the proposed rule, require that physicians give a copy of the patient's medical record electronically on request. The intent of this requirement is noble; however, we are very concerned that in the absence of a standard for distribution, and a lack of standard security protocol, such an electronic and portable copy may not be usable as intended. The record might not function properly, or in the future be compatible with other systems. For example, a patient with a new cardiac stent may be discharged today with an electronic copy of their hospitalization on a USB drive. The patient carries it with them for three years. One day she visits an ER with chest pain. If the USB drive was supplied before standards are set, and it is not backwards compatible, the patient will have held the belief that they had an accessible file when, in fact, they do not.

For security purposes, in some hospitals the USB ports are locked down so as to prevent personal health information from leaving the hospital. Consequently, such a practice also prevents the information from being uploaded for review. We recommend deferring implementation of the electronic or portable copy of the patient's records until standards for portable patient records are defined and implemented.

The challenge is that vendors will attempt to connect with those PHRs in a variety of ways. Some of those providers will be correct, and some of those vendors will be correct, and some of them will not. Once the standards are applied, those who are not will have to switch. And that is a concern as well.

With regard to medication reconciliation, the industry continues to struggle to identify the best practice in medication reconciliation. Absent a best practice, we believe it's premature and counterproductive to hard-wire such a complex process, without knowing the best approach and the impact of the process on patient care and outcomes. We urge CMS to remove this requirement for eligibility, and recommend that funding be identified to study medication reconciliation, and also to identify best practices to follow in the future.

Pending Standards, Architectures Require Attention

Meaningful use requires significant interconnectivity, and it is crucial that a standard architecture be constructed in order for information transfer to be successful. At this time, most health exchanges are not capable of completing this task, and the standards are still evolving. The burden will be placed on physicians to purchase interfaces which may not be active in the future. We recommended to CMS that certification require EMR vendors to provide standard interconnectivity interfaces as part of the basic package, once those are defined.

Internet access. Even in New York City, access to high-speed Internet is difficult for some clinics, and for many inner-city neighborhoods. For rural areas in upstate New York and western New York, that's the case as well. National focus on creating an Internet gateway for healthcare is one that should be supported, and one that we would support in New York State.

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Patient Privacy

My experience has been that most administrators and lawyers worry more about privacy than patients do. When a patient is in the emergency room with their relative who's sick, the last thing they want to hear is that they need to go across town to get a copy of an X-ray report, while their loved one lays on a cold gurney. Consumers live in the age of information, and by and large, they expect that their doctors will have the necessary information to treat them. They also expect, however, that their information will remain private. Information about even sensitive

topics such as mental illness is vital to accurate diagnosis, prescribing of medications, safely composing a plan of care that's realistic for the patient, and ensuring that the appropriate level of follow-up is available to match the patient's needs and resources. Patients with mental illnesses and other sensitive conditions need to be educated about privacy as well. They need to know that as medications become more complex, it's more important than ever for doctors to have a complete picture prior to initiating treatments. Similarly, doctors and other healthcare workers need to be educated about how and when to access sensitive information.

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We also need to be vigilant about carefully reviewing and sharing sensitive information. The New York ACP can play a vital role as a partner with the New York State Department of Health in educating physicians around privacy and security. We can all agree that timely communication of abnormal results with patients and other caregivers is a primary patient-safety concern. The proposed rule equates each case by requiring patients to have their results within ninety-six hours of availability for a subpopulation who want to access results electronically. But this is regardless of the patient's clinical context. The challenge of such a mandate is that clinical situations are different. Many tests require several weeks to complete, particularly pathology reports and tests. Communication with patients is more efficient when the whole picture is available at the time of communication. This way, not only the abnormalities, but the plan to address them, can be conveyed. Absent this, communication becomes piecemeal.

When a doctor issues a verbal order to a nurse, the nurse now repeats that order back to the doctor. And that's a standard process, and a process that's becoming adopted more widely. And so, when a resident gives a verbal order to the nurse on the unit, the nurse repeats that order back, and then the resident confirms it. What we don't have are standard communication processes with patients. So, I might present information about medications to a patient in a different way than to my nurse, and then in a different manner than to the pharmacist. I think that's where we have to work first, identify a standard communication process. And then build in electronic supports of that process, both in patient portals and in the things that we give patients electronically. But absolutely everybody needs to be working together,

Quality Metrics

Quality metrics tell part of a complex story about the effectiveness of care. More importantly, quality metrics spark the important dialogue necessary to focus individuals to take action. Information generated from electronic systems can be analyzed on a large scale, allowing for better understanding of the areas where medicine is most successful, and those where improvement is possible. However, quality measurement is a complex task requiring a significant investment in time and infrastructure. The New York Chapter of the American College of Physicians believes that the recommended quality measures must be reconsidered. The steps to ensure accurate quality data are approximately fourfold: Harmonizing of standard measures across states, payers, and government agencies; testing the methodology for collection of data; reviewing it for integrity and accuracy; and then assessing if the measures have had the proven impacts on outcomes. This is a commitment of time that extends far beyond the technology. Furthermore, ongoing effort is required to maintain the integrity as the underlying systems are enhanced. For example, if a new template is added to a system, like a progress note or a nurse's note, we need to incorporate and to ensure that the data on that new template is accounted for in the quality report, otherwise it will be missing. This is an important and non-trivial task, and it's an area that I have personally had quite a bit of experience in.

Data collection needs to be actionable, and root-cause analyses need to occur so improvements in quality of care will occur. Data should not be collected simply because it can be collected. Only meaningful data should be collected for meaningful use. Therefore, in the early phases of adoption, subspecialties should not have to report quality metrics unless they are truly meaningful. Instead, emphasis should be placed on ensuring that consultation reports are sent to the referring physician in a timely manner. Quality metrics for subspecialists needs to be developed and vetted in order to assure that data collection will improve outcomes, and this will take some time.

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Several of the indicators require access to information from across different providers and locations. For example, measures regarding stroke care incorporate information from two sources at least: the inpatient EMR and the outpatient EMR. How will the eligible provider be accountable for activity in hospitals, particularly when the patient receives emergency care at hospital where they don't admit patients? Moreover, how will that information get into the eligible provider's electronic health record for quality indicator computation? In the early phases of ARRA, physicians

should be reporting on metrics and data which they have within their own systems, and not require information from other systems. We recommended that in the first phase of meaningful use, a minimum number of indicators be required. This will give eligible providers time and experience with these new processes and maximize the potential for success. Additional measures should be added as the program matures.

> "It is not the data that is collected, but the analysis of that data that really makes the difference."
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It is not the data that is collected, but the analysis of that data that really makes the difference. Many practices are not versed in management techniques, such as lean thinking and six sigma principles. And these processes need to be incorporated into practice to leverage the technology and produce redesign. The New York Chapter of the American College of Physicians believes that there are significant opportunities to align the incentive program requirements with HIT requirements of other emerging incentive programs. We appreciate that funds are being distributed for the incentive program, and that they serve as a subsidy, but are not reflective of the true costs of implementation. Therefore, we strongly urge that New York State not expand functionality requirements beyond those required under ARRA. Doing this will only complicate and frustrate providers. For example, vendors, given the opportunity to charge additional fees for state versions of software, will simply pass this cost onto physicians. Additional costs are unsustainable for physicians facing inadequate reimbursement rates, fee cuts associated with the Medicare sustainable growth-rate formula, the SGR formula, and other increasing practice overheads and costs. Variation between state and federal programs will be counterproductive to the overall goal of full adoption, and we strongly suggest that the principle of uniform requirements between state and federal programs apply not only to ARRA but to any program involving health information technology in the state, such as e-prescribing or patient-centered medical homes.

The Needs of Hospital-Based Providers

The New York State Chapter of the American College of Physicians believes that omission of an incentive program for hospital-based physicians and house staff will reduce the effectiveness of electronic medical records. The NYACP is concerned that the incentive program excluded these providers. These physicians work in emergency departments, in hospitals, and also in hospital ambulatory care. If such

providers are not using technology, then the community-based eligible providers won't benefit from the flow of information across these settings. This has a significant impact on care transitions, as we've discussed, not only from inpatient to ambulatory but across all transitions of care. Similarly, it's our belief and recommendation that physician-training programs and their associated faculty medical practices be considered as a crucial part of this incentive program. Physicians in training should be heavily exposed to the benefits of this program, and/or an integral part of their clinical experience, both in acute- and ambulatory-care settings. This will allow them to understand the value of health information technology, and will prepare them to participate when starting their own practice or joining an existing practice.

Finally, physicians who are new to practice, along with many special physicians, work in multiple locations, among them private practices, clinics, and hospitals. When a physician practices in multiple settings, the incentive dollars should be made available to the smaller practice, which requires considerable technical and financial resources to implement the technology. The ARRA allows Medicaid incentive programs for hospitals to be released in advance of full implementation, and we support this approach and suggest that this same approach be extended to all eligible providers. With the front-loading of incentives, we believe that there will be an increase in adoption rates by providing more of the capital necessary to bring the system up. And this would result in greater data availability and more value to physicians and to consumers.

National Standards

> "... physician-training programs and their associated faculty medical practices should be considered a crucial part of this incentive program."
>
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Privacy is a very important consideration when it comes to health information; however, maintaining privacy in a health information exchange that spans across the country will require a common set of rules and regulations. Today, the rules governing privacy are different from state to state, presenting major obstacles. In this state, there are significant differences even between programs, such as general medicine and behavioral healthcare. There needs to be a national standard which all states adhere to. Only then will the industry invest the necessary research and development dollars to meet the standard so that the interstate data transfer, as well as transfer within the state, can be accomplished in a seamless and private manner.

Authentication

When aligning technology solutions, one of the most important considerations, and often one of the most difficult, is creating mechanisms to authenticate users in an easy and straightforward manner. In the information age of today, we all have many user names and passwords, and we all would probably agree we don't need any more. Thus when considering how eligible providers will communicate with each other across the state, we should strongly consider leveraging existing infrastructures. The New York State government has already created the Health Provider Network, which is not only an excellent source of information and alerts, but also has a tested and true model, and is already up and running. We suggest using this existing infrastructure for authentication, to health information networks and reporting systems; however, we caution that the means to access such a system must be user-friendly and should not create additional barriers.

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As a general internist practicing in primary care, I am constantly reminded of the inextricable connection between access to a patient's comprehensive health information in providing safe and effective and patient-centered care. Each week in clinic I see firsthand the challenges that ordinary people face in trying to manage facts about their health, particularly when they have complicated medical histories and chronic conditions such as diabetes or mental illness. Several months ago, a patient with manic depression came to me complaining of abdominal pain. She told me she had inflammatory bowel disease, a very serious condition. She said she had been treated at another facility, and she asked me to check her records, because she was hospitalized there about a year ago. I was fortunate in that case, because I happened to be on the staff at that particular hospital, and I had access electronically to her record. I read that she had been given a complete diagnostic work-up, and I discovered that her diagnosis was not inflammatory bowel disease as she described; rather, it was a far less dangerous condition, irritable bowel disease. When she had told this to other providers in the past, she received unnecessary medications such as steroids. Indeed, I would have sent her to the hospital if it were not for the additional information that I was able to access via the computer. I discussed her actual diagnosis with her, which she then recalled. And I also explored other possible reasons for her increase in abdominal pain. It turns out she had just changed jobs and was under an unusual amount of stress. This caused the same symptoms as in the past. And we discussed this, and I

prescribed a medication for anxiety. Together, we were able to prevent an emergency room visit and a possible hospital admission.

As in many healthcare contexts, the most vulnerable patients in society are also the individuals most in need of access to computer technology, either directly or indirectly. The uninsured, underinsured, and the elderly are more likely to have chronic illnesses, to receive services in emergency rooms, and experience fragmentation of care. The physicians and organizations who serve these individuals are highly likely to benefit from a connected health information system, which can provide continuity of information to support the continuity of care. This group of patients is less likely to have computers in their home, or to have high-speed Internet access, yet they're the most in need of computer-assisted learning intervention, such as video education in multiple languages, or healthcare portals to help them manage chronic illnesses like diabetes and asthma, or medication schedules that are complicated. As a society, we need to address this digital divide by providing better access to computers and Internet connections, so that this group can benefit maximally from HIT.

In summary, the New York Chapter of the American College of Physicians strongly believes that the acquisition and use of health information technology will revolutionize healthcare systems by providing physicians with real-time clinically relevant information necessary to improve patient safety and to lower costs. The leadership and the support for health information technology in New York State has been exemplary, and the members of the New York ACP are optimistic that this investment can improve the health and wellbeing of all the people living in this great state. We believe there are significant opportunities to align the incentive program requirements with other HIT requirements as they emerge, and we strongly recommend setting the goals that are attainable by the vast majority of physicians and will maximally benefit the patients. We strongly believe that the New York Chapter of the American College of Physicians can play a significant role by providing the tools and resources necessary to educate physicians on how to successfully adopt health information technology. We appreciate the opportunity to comment, and we look forward to providing ongoing collaboration to ensure our shared objectives and an orderly transition and a transformation of healthcare, and that providers with the greatest leap to adoption, those in small private practices or solo practices, be assisted and be able to get incentives as necessary.

"...the acquisition and use of health information technology will revolutionize healthcare systems..."

Louis Capponi, MD