



**TO:** Dr. James Figge, Medical Director, Office of Health Insurance Programs, New York State Department of Health

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**RE:** HIT Incentive Program Planning and Implementation

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Thank you for the opportunity to comment on the process the New York State Department of Health (Department) has undertaken to plan and design implementation of Medicaid Health Information Technology (HIT) incentive funds under the federal American Recovery and Reinvestment Act (ARRA). We are submitting these comments in response to your request after a briefing by the Department. We understand that you are interested in assessments and critiques of the “meaningful use” definitions and our ideas for fine-tuning those definitions, especially as they may affect special beneficiary populations. We have provided input along those lines below.

We also understand that your planning efforts would be particularly enhanced by data that Medicaid Matters New York (MMNY) might be able to collect regarding HIT use and adoption by consumers themselves. MMNY is a coalition of over 130 different consumer advocacy organizations spread across New York State. As such, we are uniquely positioned to facilitate surveys of consumers about their perceptions, beliefs and likely behavior with regard to electronic health records (EHR) technology. However, as we explained during our meeting, we would require both additional time and most likely, some financial support, in order to

undertake this kind of survey. We hope to follow up with you in the near future to investigate these possibilities so that we can provide you with further information.

## **Introduction**

The rules proposed by the Centers for Medicare and Medicaid Services (CMS) to govern the Meaningful Use of EHR technology promise significant improvements to the health care system and represent a careful balancing of the need to improve quality, safety and patient engagement without unduly burdening providers and hospitals. Overall, we support the direction CMS is taking with its definition of meaningful use.

The proposed rules could go further, however, in harnessing health information technology to better connect low-income patients and families to the health care system and better connect patient information across providers. We hope New York State can implement the rules proactively, as a means of incentivizing providers to inform and educate their patients, as well as coordinate care. We also request that New York State capitalize on the opportunity EHR technology presents for collecting data relevant to health care disparities, as well as data drawn from consumer input, in order to shine much needed light on patient-centered aspects of care quality.

These issues are discussed in greater detail below.

### **I. Communication and Coordination**

#### **A. *Communicating with Patients***

Implementation of EHR technology offers a unique opportunity to inform and educate patients in a way that facilitates their involvement in their health care and improves clinical outcomes. To maximize the opportunity for patients to learn what is most critical about their own health needs, and then act upon that information in a proactive way, ***all patients should be offered access to their EHR***, rather than making access to information subject to patient request (§495.6(e)(4)).

Patients will need educational resources in order to place their personal health information in context and understand the choices available. Systems that provide patient specific information through well-vetted content providers, such as Medline already exist, and could easily be linked to a patient's own records. For these reasons, we feel that the decision to exclude patient education resources from the proposed rule (Preamble Section II.A.2.d) is a mistake. The inclusion of patient resources in EHR would help ensure that patients receive accurate, safe, and reliable information relevant to their individual health needs.

Timing is also important in maximizing the value of EHR information to patients. Access to information from the EHR should be offered to patients immediately after they receive services. When services are provided in an outpatient setting, all patients should be offered access to clinical summaries prior to leaving the office. When services are provided by hospitals, patients should be offered access to discharge instructions prior to leaving the hospital.

For those patients who request their EHR outside the context of an office visit or hospitalization, providers should respond in a timely manner. One of the largest benefits of EHR is the ease with which it can be accessed and disseminated to both patients and other providers. We strongly support CMS' decision to establish a time frame of 48 hours when a patient requests a copy of their medical information under the Health Information Portability and Accountability Act (HIPAA) (§495.6(d)(5)(ii)), §495.6(e)(3)(ii)). We feel similar requirements should apply to requests for EHR information. In our comments to CMS, we urged them to consider decreasing the lag time for these situations from 96 to 48 hours(§495.6(d)(6)). We urge the Department to support timely access for patients as well. Ultimately, electronic access to EHR should be ongoing and available in real time in order to afford patients the opportunity to engage fully in their health care.

Additionally, in order to ensure that all patients can make use of access to information from their EHR, printed formats must be made available. Low-income, immigrant, elderly, and other vulnerable groups tend to have limited access to the Internet. Without a paper option, health information technology could actually worsen existing disparities in health care for vulnerable groups, an unintended consequence that must be avoided at all costs. As is

discussed further below (Provider to Provider Communication and Coordination), low-income patients should never be charged for paper copies of the EHR.

Similarly, it is critically important to make information from the EHR available in languages other than English. The proposed rules already require providers to collect information about a patient's preferred language (§ 495.6(c)(5)). The incentives should take the next logical step and require providers to make relevant information from the EHR available to patients in their preferred language. Glossaries of medical terminology in non-English languages should be part of the EHR system at its inception. If the system is capable of generating documents in just Spanish, Chinese, Vietnamese, and Russian, it would cover about 80-85% of the languages encountered among low-income patients.

Ideally, the EHR system should allow a patient, at the first point of contact, to identify the language he or she speaks (as well as the language in which he or she wishes to receive written documents - because these are not always the same), and input information in the preferred language. The language preference indicator would come up each time the patient accesses the system or is contacted or sent documents by the provider. At a minimum, EHR technology should allow for computer translation of discharge and medication instructions.

## ***B. Communication and Coordination between Providers***

Adoption of EHR technology promises to address one of the most serious needs in the health care system today by providing an effective means to ensure communication between providers. With effective communication between providers, we can hope to truly coordinate care, eliminate conflicting diagnoses, reduce medical errors and duplicative tests, and eliminate conflicting treatment regimens. This need is especially pronounced for those low income Medicaid beneficiaries who also qualify for Medicare – the dual eligibles. Not only do dual eligibles tend to have much higher rates of chronic conditions in need of careful attention and monitoring, but they tend to have multiple conditions at much higher rates than non-dual eligibles, requiring coordination of their complex care needs.

The specific provider communication requirements in the proposed rules make significant headway in improving care coordination. We strongly support the recording

requirements in §495.6(c), as well as the requirement that eligible providers and hospitals perform medication reconciliation at relevant encounters and each transition of care, and provide summary care records for each transition of care or referral (§495.6(c)(13)).

In addition, we would urge New York State to take several additional steps to ensure that data-sharing among providers is effective in meeting patients' needs:

***Eliminating Costs Charged to Patients for Sharing the EHR.*** EHR technology presents an opportunity to eliminate costs that have been incurred by patients who need copies of their health records in order to apply for benefits or change providers. At present, when patients request a copy of their health records, the patient is often charged a fee for copying and mailing these paper records. The cost of electronic transmission is nominal compared to exchanging paper records, and we recommend that New York include measures that prevent providers from charging for copying and mailing when the information is transmitted electronically.

***Testing Data Sharing Processes.*** We support the requirement that eligible providers and hospitals test their EHR system's capacity to electronically exchange key clinical information(§495.6(d)(8)(ii), §495.6(e)(5)(ii)). However, in order to ensure the effective coordination of records, it is important that these tests be successful. New York State should therefore raise the threshold from one successful test to a higher number of successful exchanges.

***Patient Initiated Corrections.*** The goal of providing patients with electronic access to their health information is to enable them to be fully engaged in the management of their health care. Patients themselves are a valuable source of information about their own medical histories.

New York should establish a standard procedure for patients to provide information for and/or correct errors in their health record by contacting their provider. Instructions on updating patient records should be included in any health information disseminated to patients

and updates or corrections by patients should be immediately available to all providers associated with the patient's care.

## **II. Data Collection**

### ***A. Data Related to Disparities***

We strongly endorse the federal requirement that providers and hospitals record patient demographic data, including race, ethnicity, preferred language, and gender. (§495.6(c)(5)). We urge New York to utilize the currently applicable 80% reporting threshold going forward, in order to support efforts to better understand disparities based upon these factors.

In order for this data to effectively improve patient care, analysis must be required of the data that is reported. While we support the requirement in the proposed federal rule that providers and hospitals generate lists of patients by specific conditions for use in reduction of disparities, we think New York should be more specific and require that such lists be stratified by race, ethnicity, preferred language and gender (§495.6(c)(9)).

We also encourage New York to include a requirement that eligible providers and hospitals report a demographic profile of their patients. Not only could this data be useful in monitoring the effectiveness of the proposed EHR incentives and their impact on vulnerable populations, but this rich database could provide an invaluable resource to increase our understanding of the healthcare system across a broad and diverse base of consumers. Finally, we urge New York to maximize access to the resource such data would represent by developing systems for making reports of the data collected under the EHR incentive program publicly available.

### ***B. Data on Patient Experience***

EHR technology provides us with an opportunity to lay the groundwork for a database of patient experiences with health information technology. Patients will be the ultimate judge of whether or not EHR technology is being used to advance patient-centered care. If patients do

not notice a difference or are unhappy with the changes they do notice, the program will have failed in a very significant aspect.

In fact, EHR technology affords the opportunity to lay the groundwork for a broader database of patient experience. With the proper design, EHR technology can begin to gather data about patient experience of care coordination across a variety of care models and even payers. At a minimum, we believe patient and caregiver email addresses should be an element of the patient demographic data collection requirement (§495.6(c)(5)(i)). We also recommend that providers and hospitals be required to attest to the percentage of their patients that have been asked about their experience of care, and document the number of EHRs that have included this critical data.

In sum, as advocates for low-income consumers, we are excited about the opportunity to help shape the requirements for meaningful use of EHR. The EHR incentive program has the potential to significantly advance the goal of creating a patient-centered health care system, a system that would truly facilitate effective communication between patients and providers, allow patients to become active participants in their own care, coordinate care and reduce existing disparities in the healthcare system.

As mentioned at the outset of these comments, we hope to be able to collect data on patients' perspectives regarding the use and storage of EHR. Ultimately, the success of EHR depends upon the responsiveness of the new technology to patient needs and concerns.

Thank you for the opportunity to comment.