February 25, 2011

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Joshua Seidman
Mary Switzer Building
330 C Street, SW, Suite 1200
Washington, DC 20201

RE: Health Information Technology Policy Committee Request for Comment on Meaningful Use Stage 2

Dear Mr. Seidman:

I am writing on behalf of Molina Healthcare Inc. (MHI) to offer comments in response to the Health Information Technology Policy Committee's (HITPC) request for comment on a preliminary set of recommendations surrounding Meaningful Use Stage 2.

Since 1980, Molina Healthcare has been a leader in providing quality healthcare to those who depend on government assistance. Our commitment to our members has made us a national leader in providing affordable healthcare to families and individuals. We work with Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to provide healthcare assistance to approximately 1.6 million members in ten states.

Last year, Molina Healthcare Inc. acquired Health PAS, and formed Molina Medicaid Solutions (MMS), a subsidiary of MHI. Health PAS is a new, high-performance, real time Medicaid management information system (MMIS) that adapts quickly to regulatory and marketplace changes and meets all functional and performance requirements of the modern Medicaid system. Health PAS is the only commercial-off-the-shelf (COTS) software-based, Medicaid Information Technology Architecture (MITA) aligned, certified MMIS in the country and provides the advanced problem solving capabilities that are needed today.

Through Health PAS, Molina Medicaid Solutions serves as the fiscal intermediary for the Medicaid programs in New Jersey, Louisiana, West Virginia, Idaho and Maine. Each year, MMS processes over three hundred million healthcare claims, making payments to over two hundred thousand providers for four million people, issuing more than $24 billion in benefit payments.

The U.S. health care system has an important opportunity to fundamentally change how it manages patients' health records in ways that will directly improve the quality of care delivered

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to patients. With recent Congressional initiatives aimed at reforming the health care system to improve access to care while reducing costs, the time is right for federal agencies to implement the HITECH Act's legislative mandates and set ambitious, yet achievable goals to ensure the effective investment of federal funds to create incentives for eligible providers (EPs) and hospitals to implement the use of electronic health records (EHRs).

Molina Healthcare offers the following specific comments and recommendations to address the questions outlined by the HITPC.

1. How can electronic progress notes be defined in order to have adequate specificity?

Electronic progress notes are subject to several issues that compromise accuracy and utility. Since the advent of electronic progress notes across different hospital systems, numerous benefits and risk have been observed.[1] Benefits include less time required to complete, improved legibility and it can be shared with several users at a time. Risks include polymerization (clinical material that is cut and pasted after it has become obsolete), more notes with less meaning, and plagiarism of notes across several authors dilutes or destroys the clinical audit trail, resulting in misinformation or distortion of the patient's condition by subsequent reviewers.

Key components of electronic progress notes must support a fundamental structure (such as header level fields that reflect problem-oriented SOAP notes: subjective, objective, assessment and plan[2]) and prompt the user to complete – or mark as not applicable – specific clinical fields. Molina Healthcare encourages ONC to include these fields in electronic progress notes:

- Develop new templates to prevent any artifact duplication;
- Restrict the ability to insert available patient data from other sources into the clinical record without attribution;
- Improve and expand the problem selection options to accommodate ICD-10 needs and serve as an option to copying text lists;
- Create automated security methods to reduce erroneous and misleading copying capabilities;
- Develop policies and procedures to discourage and penalize unethical copying;
- Provide training and guidance to increase the awareness of the adverse effects created by careless copying;
- Require reference sources for all copied text used or re-used in patient records;
- Use specific fields with drop down boxes of choices for entry. Include "Other" as a choice with free text option if chosen; this option would be used infrequently if choices set up appropriately;
- Engineer minimum number of fields to be completed before allowing clinician to move on to next section;
- Include a "HELP" section in every section when problems encountered;

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[1] *Lipton MD, Mark and Robert Press, MD PhD. Electronic progress notes – Avoiding note bloat and other pitfalls, http://webdoc.nyumc.org/nyumc/files/icis/icis/attachments/electronic_progress_notes.pdf, New York University Medical Center, undated. Accessed February 1, 2011.*

[2] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1513652/

- Carry-over previous fields that do not require an update to be accurate (e.g. the patient's name and other demographic information);
- Provide a structure that adheres to common documentation practices already in place;
- Date and time-stamp each field entry by the user (name) per event;
- Enable each narrative text field to display historical responses for the listed patient during the episode of care; and
- Allow progress notes to refer and link to external imaged documentation, such as radiology film, orthodontia, lab reports, lengthy narrative reports (such as psychiatric evaluations) and other pertinent information.

2. **For future stages of meaningful use assessment, should CMS provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures (e.g., can either satisfy utilization measures for recording allergies, conducting CPOE, drug-drug interaction checking, etc, or demonstrate low rates of adverse drug events)?**

As all providers have operational variances, Molina Healthcare encourages CMS to provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures. The "one size fits all" approach should not be applied to meaningful use. This is especially important for provider networks that primarily focus on financially vulnerable populations. For example, at Molina Healthcare, we provide services to patients who have traditionally faced barriers to obtaining quality healthcare and who are under-insured or uninsured. In general, physician providers in such networks dealing with the underserved may be less technically advanced than others.

3. **What are the reasonable elements that should make up a care plan, clinical summary, and discharge summary?**

Molina Healthcare believes the regulations should follow a known standard interoperable format for communicating care plans, summaries and discharge summaries to facilitate technical adoption in the industry. HITSPC32 CCD is a known standard in the industry that technical EMR systems and hospital systems are moving to adopt rapidly for Stage 1.

Care Plans

Each care plan should include:

- Identified health issues (description and patient history)
- Diagnosis Codes (ICD-9 or later)
- Goals and Objectives (descriptions)
    - Workflow –
        - Health Problems link to Goals
        - Goals link to Objectives
        - Objectives link to Services
- Service Authorizations
    - Service Type (Inpatient, Office visit, Behavioral Health, Home Health, DME, etc.)

    - Provider Name
    - Provider NPI
    - Provider Address of Record
    - Procedure Code
    - Modifier (if applicable)
    - Service Start Date
    - Service End Date
    - Prior authorization required (Y/N)?
    - Service authorized date
    - Units approved
    - Units denied
    - Service status (Pending, Approved, Denied, Partially Approved)
        - If prior authorization is not required, default to 'Approved')
        - Status Reason (free text and/or predefined entry)
        - Denial Rationale (if applicable)
        - Reviewer Notes (free text narrative)
        - Denial Reason Citations (statutory)
- Demographic information
    - Patient
    - Family
    - Other Supports (e.g. community case worker, friends, etc.)
    - Legal / forensic
    - Custodial information (e.g. guardian ad litem, CASA worker, attorney ad litem, etc.)
- Assessments
    - Clinical / medical
        - Falls
        - Health Risk
        - Other (predefined)
    - Behavioral Health
    - Substance Abuse
    - Social
    - Forensic
    - Vocational
- Call Tracking / Contact Management
    - Contact Date
    - Contact Type (predefined)
    - Notes / Narrative
- Enrollment
    - Status (active/inactive)
    - Program (predefined – e.g. High Risk Pregnancy, Diabetes, Waiver (type), etc.)
    - Type –
        - High Risk (Tier 1)
        - Risk (Tier 2)
        - Low Risk (Tier 3)

- Special Populations – As defined by an individual state Medicaid program to target specific issues, such as improved follow-up care for a specific group of Medicaid beneficiaries in an underserved location or across funding streams to address environmental factors that complicate service delivery.

Clinical summary

A clinical summary should include the following:

- A thorough description of the prioritized core problems/needs including those to be addressed during primary treatment versus deferred for discharge/continuing care planning;
- Intensity versus severity of core problems/needs and their implications for treatment including special alerts and precautions;
- Expectations of treatment and ability of patient/client to meaningfully participate and gain from involvement in treatment;
- Patient motivation toward recovery, relapse potential, and specific relapse prevention triggers (for Chemical Dependency);
- Expectations of treatment and nature of family participation in treatment;
- Assessment of obstacles toward discharge;
- Assessment of patient/client strengths/resources that can be maximized during treatment;
- Clinical strategies and/or rationale for development of the master treatment plan;
- Beginning development of continuing care plan;
- Diagnosis Codes (ICD-9, ICD-10, DC 0-3,, Description (free text OR predefined), Behavioral Health formatted 5 Axial diagnostic schema, etc.); and
- Assessment results (lab values, other assessments).

Discharge Summary

Discharge Summaries should be communicated using HL7 Discharge standards, and should include codified directions for medications and follow up orders (labs, radiology, office visits) as well as clinical referrals. These should continue to be communicated in the standard HL7 formats, with additional requirements for codification of data related to the details of discharge notes to keep the data as interoperable as possible. The discharge summary should include the following elements:

- Chief complaint/ Initial physician exam;
- History of present illness;
- Review of systems (organ systems) including family/social issues;
- Procedures performed and care, treatment, and services provided to the patient;
- Hospital course;
- Discharge diagnosis and orders which include medications, follow visits with physicians/other healthcare professionals and additional treatment/services at a different level of care (outpatient, home, SNF, custodial care facility);

- Comprehensive and reconciled medication list; and
- List of acute medical issues, tests, and studies for which confirmed results were unavailable at the time of discharge and that require follow-up.

4. **What additional meaningful-use criteria could be applied to stimulate robust information exchange?**

Molina Healthcare believes consideration should be given to health care professionals ineligible for government incentives with EHRs. The monetary incentives currently contemplated by the federal government do not apply to the entire spectrum of care providers. As an example, although physician assistants and nurse practitioners are eligible for the Medicaid EHR incentive program, they are not eligible for the Medicare EHR incentive program. In parts of our nation, particularly in rural and isolated areas, nurse practitioners and physician assistants provide independent and critical care to Medicare patients. As a result, we encourage the Committee to consider expanding the types of providers eligible for the program.

Molina Healthcare believes that more emphasis should be placed on translating meaningful use to bending the cost curve and quality of care. It is anticipated that the widespread adoption of EHRs will significantly improve the quality of clinical care. Nevertheless, without concerted effort and commitment, this opportunity for bending the cost curve and improving quality of care could go unrealized. Most health systems have already made and will continue to make large investments in interoperable EHR systems, spending tens of millions of dollars on systems that will push them farther along the meaningful use spectrum. However, this may not translate to an immediate return on investment.

Molina Healthcare believes that incentives should also be tied to implications for patient-centered care. There is no question that wiring the country is a step in the right direction. Patients are concerned with the amount of typing required of their doctors by the new EHR solutions during their clinical visits. They see a significant lack of one-on-one communication and discussion. Education and health literacy are vital in reforming health care not only by empowering patients to take control of their own healthcare issues but also to understand the health information technology reforms taking place in their doctor's office. Educating patients about their own medical conditions as well as the advantages of health IT allows them to play an active role in shaping the future of their healthcare decisions. As noted by other, we also consider the following are some essential functions of health IT that patients care most about:

1. The ability to schedule appointments with clinicians online during or after official office hours;
2. A mechanism to receive relevant health advice or recommendations online; and
3. An integrated and meaningful capacity for discharge instructions after a hospitalization. Given the emphasis on discharge instructions and clinic visits in the core set of criteria, the next step is a patient-centered approach to ensuring that a clinic visit in the outpatient setting related to a hospital discharge is also "bundled" together with the

original hospital visit, creating a more integrated picture of a particular patient's care continuum.[3]

5. **What strategies should be used to ensure that barriers to patient access – whether secondary to limited internet access, low health literacy and/or disability – are appropriately addressed?**

Where access to information is not a problem, its relevance and applicability is often poor. Too often the information and method of communication have not been tailored for the specific populations being addressed. The information may be scientifically accurate but be unacceptable, and even incomprehensible, to those for whom it has been intended.

Most Americans have some form of health insurance coverage, but the number of people who are under-insured or uninsured continues to increase as a function of declining employment-based insurance plans. However, increased insurance coverage will not solve the access problem. A range of non-financial based barriers prevents patients from receiving health care services in a multitude of settings and circumstances.

For any individual, these barriers might include education, language, personal experiences, attitudes and beliefs, unhealthy lifestyles, poor nutrition, provider's attitudes and beliefs, transportation, social support, and/or health professional supply and distribution. In addition, race, ethnicity, gender, economic status, geography and environment are other important factors to consider. More broadly, non-financial barriers are distributed unequally across the population and are felt in greater extent and depth in the poor, minority and other vulnerable populations. This may be due to not only the amount of care they receive but also the content, quality, and continuity of what care they do receive. Molina Healthcare believes it would be appropriate to explore the use of information in an audio/video format for those members who would prefer that system as their mode of learning. Also, since cell phone use is high across all populations, including Medicaid, the use of texting programs could improve access for those in our populations.

Addressing non-financial barriers to primary health care is critical if improved access is to be achieved. To significantly advance the health status of the American people, research directed at the examination of non-financial barriers to access and service utilization is essential.

6. **In stage 1, as an optional menu objective, the presence of an advance directive should be recorded for over 50% of patients 65 years of age or older. We propose making this objective required and to include the results of the advance-directive**

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3 *Many of the view expressed in response to question #4 are found in the article: "Making 'Meaningful Use' Meaningful for Patients and Health Care Providers," by Kavita Patel, M.D., M.S. . October 6, 2010 http://www.ihealthbeat.org/perspectives/2010/making-meaningful-use-meaningful-for-patients-and-health-care-providers.aspx#ixzz1EzhJTEuS*

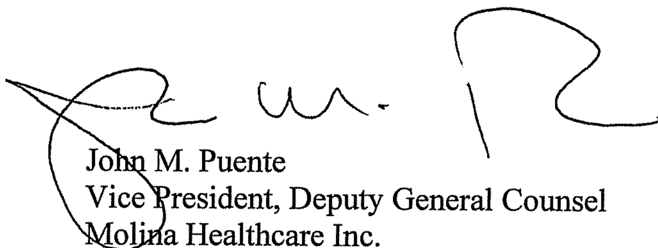
discussion, if available. We invite public comment on this proposal, or to offer suggestions for alternative criteria in this area.

Having advanced directives recorded for over 50% of patients 65 and older may be a challenging goal to achieve, especially for hospitals, as they currently have less than 20-25% advanced directives recorded. Providers will need to track directives with external providers on potentially different systems, making this an even greater challenge for them.

We support initiatives to advance the use and exchange of health information and to make such information more readily available to providers and other covered entities. We believe this can lead to improved quality and efficiency of health care services. Providing incentives through the Medicare and Medicaid programs is a logical approach to achieving these objectives.

Thank you for considering our recommendations and for the opportunity to provide comments. Your decisions on these issues will have wide-reaching implications on health plans, the adoption of health information technology and the broader health reform effort.[4]

Sincerely,



John M. Puente
Vice President, Deputy General Counsel
Molina Healthcare Inc.

[4] Some of our comments are shared by various other stakeholders and may be reiterated in other comments to HITPC.