



Charles N. Kahn III  
President

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**VIA EMAIL & COURIER**

David Blumenthal, M.D.  
National Coordinator for Health Information  
Technology  
Department of Health and Human Services  
200 Independence Ave. SW, Rm. 729-D  
Washington, DC 20201

Jonathan Blum  
Director  
Center for Medicare Management  
Centers for Medicare & Medicaid  
Services  
200 Independence Ave., SW Rm. 314-G  
Washington, DC 20201

Dear Dr. Blumenthal and Mr. Blum:

The Federation of American Hospitals (“FAH”) has taken a leadership role in quality improvement initiatives designed to foster the highest quality patient care possible. As a founding member of the Hospital Quality Alliance, the FAH has worked very closely with the Department of Health & Human Services (“HHS”) to support a variety of federal policies that strive for high quality patient care, and we look forward to continuing that important collaborative relationship.

HHS is currently considering policies to implement funding for “meaningful users” of electronic health records (“EHRs”) through the American Recovery and Reinvestment Act of 2009 (“ARRA”). The ARRA is intended to accelerate the adoption and use of EHRs by providers and clinicians to diffuse technology in a way that fosters a better infrastructure that is integral to improving the quality of patient care. It has been suggested that “meaningful use” funding should be tied to provider performance on outcomes-related quality measures. However, our outside legal experts view the ARRA funding as tied only to accelerating the adoption and use of EHRs by providers and clinicians, and not to patient care achievements or outcomes that may be attained while using EHRs.

From a policy perspective, quality outcomes measurement is subject already to a number of federal policies in place and under consideration by Congress. Thus, it is problematic and even counterproductive for these policies to be duplicated or affected by adopting achievement-based measures for meaningful use purposes. To do so will likely undermine the Congress’ desire for wide-scale EHR adoption. Given the financial impact under multiple policies, this outcome would even be unfair and overly punitive for providers.

## **I. The Scope of ARRA Funding for EHR Users Is Limited**

The FAH is gratified that Congress included in the ARRA funding designed to accelerate adoption and use of EHRs by providers and clinicians. Increased provider usage of EHRs will aid greatly in developing a more robust public reporting system that will allow more effective collection and sharing of quality data, which will undoubtedly lead to better patient care. To achieve this goal, diffusion of new technology and development of information exchange capabilities are critically important to facilitate the free flow of information.

Over the past few months, the HIT Policy Committee has considered a framework for an appropriate “meaningful use” policy and has made recommendations to HHS. In doing so, the Committee contemplated a staged approach which included the ability to “capture and share data” in 2011, “advanced care processes with decision support” in 2013, and “improved outcomes” in 2015. However, the Policy Committee’s approach goes well beyond the ARRA’s authority to set funding policy for meaningful EHR users and would undermine the ARRA’s central purpose of accelerating the adoption and use of EHRs.

The FAH is concerned because it appears HHS may share the Policy Committee’s view and may establish “meaningful use” policy that goes beyond its statutory authority or the intent of Congress. The ARRA specifically states that to be a meaningful user, a hospital “submits information . . . on such clinical quality measures and such other measures as selected by the Secretary . . .” (ARRA §4102.) Thus, our outside legal counsel advises that a meaningful user is a hospital that submits the required information only. In its wisdom, Congress specifically tied qualification for ARRA funding to the submission of data, and left to other policies how providers and clinicians would be measured for quality of care outcomes. This approach allows for the broadest possible diffusion of EHRs to create a more robust infrastructure for public reporting and quality improvement that benefits patients and providers alike.

In contrast, the Policy Committee’s framework goes beyond the submission of data, and contemplates particular standards or goals that eventually must be achieved in order to be a meaningful user. The ARRA directs the Secretary to seek to improve the use of EHRs and quality of care over time by requiring more stringent measures of meaningful use. However, the progression that Congress contemplates ties only to expanded use of technology (such as a greater percentage of orders entered electronically), and not to actual achievement in quality measurement scores, which are wisely left to other, appropriate policies. Thus, we believe the Policy Committee’s recommended approach goes beyond the ARRA’s authority.

## **II. Tying Meaningful Use Funding to Outcomes Measurement is Problematic and Counterproductive**

Because the main goal of ARRA funding is to accelerate adoption and use of EHRs by providers and clinicians, HHS should be mindful of not adopting policy that will hurt this objective. If HHS expanded this policy beyond the submission (or reporting) of data, it will have the adverse impact of limiting provider adoption of EHRs because it will prohibit ARRA funding for those who do not satisfy the performance measures. This result would run directly counter to the reason Congress provided this funding.

A specific Policy Committee recommendation underscores why this distinction is so important. Under its framework, the Policy Committee has recommended that HHS should adopt a measure for 2013 requiring a 10 percent reduction in preventable readmissions from 2012 to qualify as a meaningful EHR user. There is a clear disconnect between whether a hospital is capturing and sharing data through an effective EHR and whether a provider reduces its readmissions over time. The focus under the ARRA should be on whether the hospital is increasing its capacity to use fully EHRs and properly share the data derived from those electronic records for better care coordination. A provider's readmission rates are affected by several factors, many of which do not relate to the use of an EHR.

Moreover, refining readmission measurement is a topic of discussion in health reform, and is under active consideration by the appropriate Congressional committees who develop Medicare payment policy. The same is true for a host of other quality outcomes-related policies, including pay-for-performance programs. It is unclear how the Policy Committee's proposed measure or any future achievement-based recommendations would be interpreted or would interact with separate Medicare payment policies. In our view, it is problematic and even counter-productive to establish these types of policies in the context of "meaningful use," especially when Congress has legislated on, or is considering, the issue for Medicare payment policy.

Finally, when a provider or clinician's performance leads to a negative financial impact under Medicare payment policy, it would be unfair and overly punitive for providers to also face a separate and potentially more significant financial impact under the meaningful user policy – whether through a denial of funding and/or ARRA's penalties. This outcome would be akin to double jeopardy for the same quality concern. Because different interests are advanced under "meaningful use" and Medicare payment policies, those policies should be administered with clear separation to avoid confusion or limited adoption and use of EHRs.

The FAH looks forward to working with HHS as the meaningful user policy is developed. We are hopeful that HHS will implement the policy consistently with the expectations of Congress. If you have any questions, please contact me, Jeffrey Micklos, or Samantha Burch of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey Micklos". The signature is fluid and cursive, with a large initial "J" and "M".

cc: Tony Trenkle (via email)  
Jodi Daniel (via email)