



Charles N. Kahn III  
President

March 9, 2010

**VIA ELECTRONIC SUBMISSION**

The Honorable Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-0033-P**  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

**RE: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; CMS-0033-P; 75 *Federal Register* 1844 (January 13, 2010)**

Dear Ms. Frizzera:

The Federation of American Hospitals (“FAH”) is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals.

On behalf of our member hospitals, I am pleased to submit the following comments on the Centers for Medicare & Medicaid Services (“CMS”) Proposed Rule to implement the Health Information Technology for Economic and Clinical Health Act (“HITECH”) provisions of the American Recovery and Reinvestment Act of 2009 (“ARRA”) that provide incentive payments to eligible professionals (“EPs”) and eligible hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use “certified” electronic health record (“EHR”) technology (“Proposed Rule” or “NPRM”). (75 *Fed. Reg.* 1,844 (Jan. 13, 2010).)

The FAH’s major recommendations for improving the Proposed Rule on the EHR incentive program include:

- Interpret “eligible hospital” in a manner that accounts for all subsection (d) hospitals, even those that operate as a group under a single provider number
- Revise the “all or nothing” approach to satisfying meaningful use by requiring fewer criteria for Stage 1 and providing additional flexibility to hospitals
- Exclude administrative functions from the meaningful use criteria
- Extend the transition to full meaningful use to 2017 and provide guidance to hospitals on the future stages of meaningful
- Delay electronic clinical quality reporting until at least 2012 and build off of the existing CMS hospital quality reporting program
- Refine the “Hospital-Based Eligible Professional” definition
- Clarify a number of specific issues related to the administration and calculation of the Medicare and Medicaid incentive payments

On March 2<sup>nd</sup>, 2010, the Office of the National Coordinator for Health Information Technology (“ONC”) issued a proposed rule to establish a temporary as well as a permanent certification program for electronic health record (“EHR”) technology. While we appreciate the ONC’s efforts to move forward with the establishment of a process for certifying EHR technology, last week’s release date marks a significant delay in a rule that was slated to be published “early in 2010.” The rule for the temporary certification process is subject to a 30-day comment period and it is unclear as to when the ONC will be able to issue final regulations. This delay has led to uncertainty in the marketplace and hesitation on the part of providers to make a substantial capital investment in products that may prove not to be a pathway to achieving meaningful use. These circumstances have compressed an already short implementation timeline for providers to qualify for incentive payments and will undoubtedly impact the number of eligible hospitals able to demonstrate meaningful use in FY 2011.

The FAH has long-supported the adoption of interoperable health information technology (HIT) as a means of improving the quality, safety and efficiency of health care delivered to patients in the United States. We, therefore, commend the federal government’s strong investment not only to spur the adoption of HIT, but also to build the infrastructure necessary to support the nationwide exchange of health information. Without the ability to access necessary information at the point of care, clinicians and patients will not realize the full potential of HIT.

We support the potential of HIT to not only improve quality at the point of care, but to improve our ability to measure quality and chart progress over time. The current hospital quality measurement and reporting enterprise has grown organically over the past several years, rooted in evidence-based measures endorsed through the National Quality Forum’s (“NQF”) consensus standards development process and multi-stakeholder collaboration between the public and private sectors facilitated by the Hospital Quality Alliance (“HQA”). As we move to a future state of electronic quality reporting, as required by the HITECH law, we strongly recommend that CMS build on the success of the current quality enterprise rather than establish a parallel reporting infrastructure.

Since the passage of HITECH, hospitals have been eagerly awaiting further direction from CMS and the ONC on the administration of the EHR incentive program and associated requirements. We believe that, if implemented appropriately, this program presents an

unprecedented opportunity to drive improvements in patient care and change the face of the U.S. health care system. Hospitals are enthused about this opportunity and committed to the migration from paper records to clinical technology solutions, and it is in that spirit that we offer the following general comments and specific suggestions to strengthen the potential of this incentive program to bring about the advancement we are all working toward.

While fully supportive of the goals of the HITECH Act and the Proposed Rule's efforts to advance those goals, we have a number of concerns with the proposed framework for determining whether an eligible hospital will qualify for incentive payments under this program. Although the Proposed Rule incorporates a 3-stage approach to meaningful use, we do not believe that it goes far enough in phasing in the requirements and allowing hospitals flexibility to choose meaningful use objectives that match their unique strategic and quality objectives, designed to address appropriately the patient needs in their particular communities.

We are further concerned that the lack of an overall vision for meaningful use will cause providers to be reactive to the latest set of regulatory requirements instead of systematically working toward an end-goal of having all of the necessary technologies in place to promote safe, efficient, high quality care. The proposed 3-stage approach, absent guidance from CMS on future stages of meaningful use, also runs counter to the business reality for hospitals that often enter into multi-year contracts with HIT vendors and is likely to result in hospitals incurring significant add-on costs for making modifications to comply with regulatory changes.

We believe that guidance on the objectives and adoption targets CMS is considering for the later stages of meaningful use, subject to ongoing evaluation and modification through rulemaking, would best serve America's hospitals and the patients they care for. We are eager to see a systematic and ongoing evaluation of this program, based on defined metrics, to determine where challenges exist and where mid-course correction may be necessary.

## **I. DEFINITIONS**

### **A. Certified Electronic Health Record Technology**

Under HITECH, EPs and eligible hospitals are required to use "certified EHR technology" to qualify for incentive payments. In the NPRM, CMS proposes to use the definition of certified EHR technology adopted by the ONC in its related interim final rule specifying an initial set of standards, implementation specifications and certification criteria for EHR technology.

While we commend the ONC and CMS for closely coordinating these rulemakings by mapping the certification criteria to the proposed "meaningful use" objectives, we remain extremely concerned about the delay in the rulemaking to establish the policies for the certification of HIT and the process a certification body will need to follow to become an authorized certification entity. The certification process proposed rule was slated to be published "early in 2010" but has been delayed to a release date near the end of the incentive payment Proposed Rule's comment deadline. In the Proposed Rule on Certification Programs for HIT released on March 2<sup>nd</sup>, 2010, the ONC notes it is likely that the temporary certification entities

will not exist until May or June 2010. The FAH fears that this delay and related implementation challenges will delay EP and eligible hospital access to certified EHR technology, a necessity in order to qualify for incentive payments.

We believe that the ONC and CMS should collaborate to adopt a “grandfathering” policy under which certain EHR technology would be considered “certified” for purposes of qualifying for EHR incentive payments. For example, EHR technology previously certified by the Certification Commission for Health Information Technology (CCHIT) could be considered acceptable for some period of time. This might, for example, require ONC and CMS to agree that the functionalities of such EHR technology, when properly used by EPs and eligible hospitals, would satisfy applicable meaningful use requirements, at least for the first year or two of the incentive program. There undoubtedly are other ways in which a “grandfathering” policy might be structured. In any case, absent such a policy, we are concerned there would be significant delays in making certified EHR technology available to EPs and eligible hospitals.

## **B. Definition of Hospital**

Under the “meaningful use” policy, incentive payment are available for “eligible hospitals” that are deemed to be “meaningful users” of certified EHRs. The new law defines “eligible hospitals” as “subsection (d) hospitals,” which is a term further defined in another section of the Social Security Act. The proposed regulation at §495.4 defines eligible hospital as “eligible hospital as defined under §495.100 or Medicaid eligible hospital under subpart D of this part.” Proposed §495.100, which applies to Medicare incentive payments, defines “eligible hospital” as a hospital subject to the prospective payment system specified in §412.1(a)(1) of this chapter, excluding those hospitals specified in §412.23 of this chapter.”

Later in the Proposed Rule, where CMS addresses measuring meaningful use, CMS states that “[f]or purposes of this provision, we will provide incentive payments to hospitals as they are distinguished by provider number in hospital cost reports,” which is also now known as the CCN. (75 *Fed.Reg.* 1,911.) Thus, CMS is proposing to equate subsection (d) hospitals to those hospitals that file a cost report under one provider number. However, no such parallel policy is set under the definitional sections of the Proposed Rule.

We understand why CMS would propose the provider or CCN number as one way to identify eligible hospitals for payment incentive purposes. However, the FAH believes this approach should not be the exclusive way to identify eligible hospitals. There are instances where a single provider number may encompass multiple hospitals or campuses from a single integrated delivery system. In such instances, the use of a provider number as the only determining factor creates an imprecise outcome, and runs counter to the statutory directive that all subsection (d) hospitals be eligible hospitals for incentive payment purposes.

As an important part of the economic stimulus package, the goal of the incentive payment programs is to promote the widespread adoption and use of EHRs to improve patient care. As you know, the Medicare and Medicaid payment incentives are calculated using a per-hospital base amount plus a capped per-discharge amount. When using a provider number to represent an eligible hospital, multi-hospital systems with one provider number are greatly disadvantaged in that they will receive only one base payment (despite having more than one subsection (d)

hospital) and are more likely than single-hospital provider numbers to be affected by the per-discharge cap. This outcome has real world impact that will hinder, not promote, the adoption and use of EHRs among multi-hospital systems.

Moreover, this approach could lead to equally disparate treatment with regard to the penalty phase of the meaningful use policy that is triggered in 2015. Under one possible scenario, a three-hospital system that operates under one provider number could be subject to penalties even if two of the hospitals are in compliance with the meaningful use rules, but the third hospital is not. In that situation, we believe the penalty would be overly punitive in light of the fact that two hospitals are in compliance with the policy.

The FAH strongly believes that to meet the statutory directive, CMS must interpret “eligible hospital” in a manner that accounts for all subsection (d) hospitals, even those that operate as a group under a single provider number. We do not oppose CMS using the provider number as a qualifying criterion, but it should not be the exclusive means to qualify. Instead, we believe multi-hospital systems operating under one provider number are entitled to an alternate way to qualify for incentive payments.

We urge CMS also to allow subsection (d) hospitals to show that they qualify for incentive payments as an “eligible hospital” if they can show a distinct emergency room or distinct hospital license from the other hospitals operating under the same Medicare provider number. Another alternative would be to build upon the use of the concept of “remote locations of a hospital.” Under the provider-based rules, CMS recognizes the reality of multi-campus hospital systems with one provide number and identifies certain campuses as remote locations of a hospital. Further, for inpatient hospital payment purposes, CMS even permits hospitals to establish wage indices that are appropriate for the location of each hospital campus within a system. The FAH strongly urges CMS to consider using a similar approach to identify distinct hospitals within a system that may operate using one provider number and provide meaningful use incentive payments to each hospital. Such an approach would best meet the language and intent of the statutory directive to make incentive payments to each “subsection (d)” hospital. It is also important that such policy is made clear in the definitional sections as appropriate, and not just discussed in the preamble in a different context.

### **C. Payment Year**

The Proposed Rule and commentary do not address the consequences to a hospital of failing to qualify as a meaningful user after a hospital qualifies for its first payment year. For example, once a hospital qualifies as a meaningful user for its first payment, but has a lapse in its use of EHR technology during the next federal fiscal year, will the hospital in its next qualifying year be in its second or third payment year for purposes of the transition factor. We believe the resolution of this issue will center on CMS’ interpretation of 42 U.S.C. § 1395ww(n)(2)(G), which defines the term “payment year.” Therein the statute provides: “The terms 'second payment year', 'third payment year', and 'fourth payment year' mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.” CMS should make clear its intention with respect to this issue.

## II. DEFINITION OF MEANINGFUL USE

### A. Common Definition of Meaningful Use under Medicare and Medicaid

The NPRM proposes to create a common definition of meaningful use that would serve as the definition for providers participating in the Medicare FFS and Medicare Advantage EHR incentive program, and the minimum standard for EPs and eligible hospitals participating in the Medicaid EHR incentive program. The Proposed Rule clarifies that if a state has CMS-approved additional meaningful use requirements, hospitals deemed as meaningful users by Medicare would not have to meet the state-specific additional meaningful use requirements in order to qualify for the Medicaid incentive payments.

CMS requests comments as to whether compelling reasons exist to give the states additional flexibility in creating disparate definitions and the agency asks that interested parties also comment on whether the proposal of deeming meeting Medicare as sufficient for meeting Medicaid remains appropriate under the separate definitions. We fully support CMS' proposal that for hospitals eligible for both the Medicare and Medicaid EHR incentive programs, meeting the Medicare requirements for meaningful use should be sufficient for meeting Medicaid. We believe the practical reality is that very few (if any) general acute-care hospitals would seek incentive payments only under Medicaid and not under Medicare, and therefore, allowing disparate definitions for a small number of hospitals would have little material impact. Therefore, the FAH strongly recommends that CMS develop a single set of requirements for meaningful use that applies to both Medicare and Medicaid and not allow states to create disparate definitions for Medicaid eligibility purposes that impose additional requirements.

Hospitals with a high volume of Medicaid patients should not be subject to more stringent requirements for meaningful use than those required under Medicare. It seems counterintuitive that hospitals caring for our nation's most socio-economically disadvantaged patients be subject to a higher bar in meeting meaningful use. These hospitals face a unique set of challenges in caring for a high Medicaid patient population and could, in the end, reap some of the greatest benefit from the use of HIT to promote quality, efficiency and patient safety. However, if they are held to a standard of meaningful use that is unachievable, there is a greater chance that they will not be able to advance their implementation of HIT systems due to resource constraints resulting from their inability to access incentive payments.

The goal of this incentive program is to move our health care system toward widespread adoption and use of interoperable HIT. The potential for 50 different definitions of Medicaid meaningful use will not serve this goal and would create administrative challenges for health care systems with hospitals in different states subject to different meaningful use requirements. Thus, we urge CMS to develop a single definition for meaningful use applicable to both Medicare and Medicaid.

## B. Framework for Meaningful Use of Certified EHR Technology

At the core of HITECH was the concept of providing incentives not simply for the purchase of HIT, but for actively using technology. Congress specified broad requirements for meaningful use in HITECH, but left the details of these requirements to be defined by CMS. For eligible hospitals, the Proposed Rule includes 23 criteria and associated measures as the definition of Stage 1 meaningful use. The NPRM further proposes an “all or nothing” approach by requiring eligible hospitals to satisfy all 23 criteria to qualify for incentive payments.

The FAH has serious concerns with the NPRM’s framework for meaningful use. While appreciative of CMS’ recognition of the need for staging the meaningful use requirements, we do not believe the proposed 3-stage framework is the best means of encouraging hospitals to advance their adoption and use of technical capabilities over time. We believe that in order to maximize the potential of the EHR incentive program to result in a nation-wide, interoperable HIT infrastructure, CMS should provide guidance on the roadmap for meaningful use at the outset of the program. Our recommendations for improving the proposed framework for meaningful use include:

- **Revise the “All or Nothing” Approach to Satisfying Meaningful Use**

The Proposed Rule incorporates an “all or nothing” approach to determining which hospitals will qualify for meaningful use incentives. The FAH believes strongly that this approach will prevent a large number of hospitals from entering the incentive framework in the early years of the program. The goal of a staged approach would seem to be to build functionality over time in a way that supports systematic implementation to ensure that patients are not negatively impacted by associated changes in workflow and care processes.

The staging of meaningful use in the Proposed Rule creates a steep incline for hospitals unable to achieve meaningful use in the early years of the incentive program. If a hospital does not adopt in 2011 or 2012, it will be extremely difficult, under the proposed framework, to remain “on the escalator” to full meaningful use. The FAH therefore recommends that CMS stage the transition to full meaningful use by establishing a four-stage approach that builds toward the final stage of meaningful use in 2017 (as outlined below).

**TABLE 1. FOUR STAGES OF MEANINGFUL USE**

|         |                         |
|---------|-------------------------|
| Stage 1 | 2011-2012 Payment Years |
| Stage 2 | 2013-2014 Payment Years |
| Stage 3 | 2015-2016 Payment Years |
| Stage 4 | 2017 Payment Year       |

The HIT Policy Committee’s workgroup on meaningful use put forth a recommendation at the Committee’s February 17<sup>th</sup> meeting to allow eligible providers to defer a certain number of criteria in some priority categories. Under their proposal, eligible providers would still need to meet roughly 80% of the measures of meaningful use. Because we support changing the NPRM’s “all or nothing” approach, we appreciate the workgroup’s recognition of the need to

scale back the number of proposed requirements to make meaningful use more achievable for eligible hospitals and EPs in the early years of the program.

The FAH recommends that CMS use a combined approach to satisfying meaningful use by requiring certain core functions but also by providing a degree of flexibility in allowing hospitals to self-select a certain number of objectives. We believe the current number of proposed objectives sets an unachievable bar for hospitals in the first two years of the incentive program. While there will be a great deal of discussion and debate about what the exact number of objectives should be, our ongoing conversations with HIT executives and thought leaders within our membership lead us to believe that the appropriate number is around half of the total criteria proposed (this assumes that CMS accepts the FAH's recommendations, both of which are outlined below, to delay clinical quality reporting and exclude administrative functions from the definition of meaningful use).

For the 2011 and 2012 payment years (i.e., the NPRM's Stage 1), the FAH recommends that CMS require ten meaningful use criteria by establishing a "core set" of objectives and allowing hospitals flexibility to self-select additional objectives from the remaining list of proposed Stage 1 criteria. We believe an even distribution between required and self-selected criteria (i.e., roughly five required and five self-selected), would strike a fair balance between the need for structure in the incentive program and the desire of hospitals to chart an adoption course that best meets the needs of their patients and communities.

We anticipate that CMS will expand the initial list of objectives in future rulemakings to build toward the set of functions that make up a meaningful inpatient EHR. Any expansion of meaningful use objectives should be incremental and informed by the state of the technology as well as ongoing program evaluation. Therefore, Stage 2 should include a reasonable number of meaningful use objectives, not to exceed the number of criteria proposed in the NPRM for Stage 1.

- **Exclude Administrative Functions from the Meaningful Use Criteria**

The FAH is concerned about the inclusion of administrative functions in the definition of meaningful use. Hospitals are already widely using electronic systems to perform the administrative functions listed as meaningful use requirements in the Proposed Rule and these functions are already covered under the HIPAA administrative simplification regulations. By including these administrative functions (i.e., electronic insurance eligibility checks and electronic claims submission), CMS is requiring that these objectives be satisfied using "certified EHR technology." Depending on how one interprets this requirement, hospital may either need to: (1) have existing administrative systems certified, or (2) perform these administrative functions using EHR technology.

We are concerned that given the delay in the "certification rule," hospitals constructing modular EHR systems will have great difficulty working with non-clinical information technology vendors to ensure that their administrative systems are certified to begin demonstrating meaningful use. We further believe that it is inefficient to require hospitals to abandon their long-standing administrative systems, and their financial investment in those systems, to perform these functions through certified EHR technology when the two systems are

almost always integrated. Therefore, CMS should remove all non-clinical functions, including the proposed electronic insurance checks and electronic claims submission, from the meaningful use criteria.

- **Provide a Roadmap for Meaningful Use that Gives Guidance to Hospitals**

CMS requests comments on the proposed 3-stage pathway of meaningful use. The FAH is concerned that by defining the additional requirements for each stage of meaningful use through biannual rulemaking, with no indication of the objectives CMS is considering for the later stages, hospitals will not have a broad roadmap to guide their internal strategic planning process aimed at developing a complete pathway for how to meet the highest level of meaningful use. The lack of a complete vision for meaningful use will cause providers to scramble to meet the latest set of regulatory requirements instead of systematically working toward an end-goal of having all of the necessary technologies in place to promote safe, efficient, high quality care. The reactive nature of this approach will be disruptive to hospitals' strategic planning and force rushed implementation of new technologies that will have serious and potentially negative implications for workflow and patient care.

We further believe that the proposed 3-stage approach does not account for the business reality of the vendor contracting cycle. Hospitals often enter into multi-year contracts with health IT vendors and the need to rapidly implement new functions or upgrade technologies would likely force these hospitals to incur large add-on costs in addition to the underlying costs of implementing the original system. A roadmap for meaningful use, subject to review and modification through future rulemakings, would mitigate these concerns and allow hospitals to advance their strategic plan over the course of the full term of the EHR incentive program without significant disruption to ongoing implementation efforts. It would also provide HIT leaders within hospitals with valuable leverage to keep their organizations consistently advancing toward meaningful use by upgrading and investing in new technology.

CMS currently uses a similar approach for adding new quality measures to the Reporting Hospital Quality Data for Annual Payment Update ("RHQDAPU") pay-for-reporting program. In the annual inpatient PPS proposed rule, CMS proposes not only the measures for that fiscal year, but includes measures that could potentially be proposed in future years. We believe a similar approach should be applied for meaningful use objectives in the EHR incentive program. CMS should therefore provide guidance on the potential list of criteria and adoption targets for the later stages of meaningful use in the upcoming final rule and provide an opportunity for public comment on those objectives. This list should comprise the functions that make up a meaningful inpatient EHR, while recognizing that advances in technology and the results of program evaluation could lead to modifications through future rulemakings.

In June 2009, the HIT Policy Committee made recommendations on the objectives for meaningful use in 2011, 2013 and 2015. While the Committee's recommendations were slightly less detailed for 2013 and fairly broad for 2015, the Committee Members clearly acknowledged the need to provide guidance on the future stages of meaningful use. While we do not support all of the objectives recommended by the Committee, we appreciate their efforts to advance a framework that would give direction to providers on the glide path to full meaningful use.

Providing a roadmap for future meaningful use objectives would also allow hospitals to understand which functions, implemented prior to the release of this Proposed Rule, they may get credit for adopting and using in the future. Many hospitals have already implemented certain technologies, which may go beyond those included in the NPRM, to advance patient safety and clinical quality, such as bedside medication administration. Meaningful use should not become a disincentive for hospitals to implement functionalities that will yield important advances in patient care.

For hospitals that began to implement or plan for the implementation of HIT systems prior to the passage of HITECH and this Proposed Rule, it is critical that meaningful use not be a barrier to those efforts. Again, given the variation in adoption paths for hospitals, the EHR incentive program should not promote reactive implementation of new technologies. Given limited resources and the reality of difficult economic times for providers, it would run counter to the goals of this program to create an environment in which there is so much uncertainty that hospitals abandon efforts to implement advanced technologies.

- **Extend the Transition to Full Meaningful Use to 2017**

When HITECH became law in February 2009, hospital began to plan for the deployment of new HIT systems. However, efforts to have technology implemented in time to enter the incentive framework in FY 2011 were predicated on the assumption that there would be “certified” products on the market to purchase. The delay in establishing a certification process and thereby having certified systems available to providers, has compressed the implementation timeline in a way that will prevent many hospitals from meeting the meaningful use requirements using “certified EHR technology” in FY 2011. The FAH believes the compression of the timeline on the front end of the incentive program warrants serious consideration for expanding the transition period to full meaningful use on the back end.

Under the staging proposed in the NPRM, all hospitals would need to meet the highest level, Stage 3 meaningful use criteria by 2015 to avoid market basket penalties. The FAH has consistently advocated a staged approach to meaningful use, recognizing that moving from very low adoption rates of HIT among hospitals to fully operational, and consistently utilized systems takes time, resources, and buy-in from clinicians. However, we do not believe that the NPRM’s staging goes far enough in providing the flexibility necessary to allow hospitals to become meaningful users prior to the beginning of the penalty phase.

The ultimate goal of meaningful use should be to promote the full set of functionalities that support quality care. We believe that the timeline laid out in the Proposed Rule does not support achievement of this goal. Rather than requiring that all hospitals are at the highest level of meaningful use by 2015, CMS should extend the transition to full meaningful use to 2017, which would still be consistent with the timelines set out in HITECH. This extended transition would not require the delay of penalties in 2015, but instead, allow hospitals who have entered the framework by 2015 two additional years to achieve the highest level of meaningful use.

### C. Measuring Meaningful Use

The Proposed Rule includes associated measures of meaningful use for each criterion. While a hospital's HIT utilization needs to be measured in order to chart progress over time, we have concerns with both the lack of an evidence base for the measures as currently structured as well as the high burden associated with calculating the denominators for several of the measures. We offer the following recommendations for improving the measurement of meaningful use:

- **Measures of Meaningful Use Should be Evidence-Based**

The FAH believes strongly that CMS should only require measures of meaningful use that are evidence-based, similar to those measures used for quality measurement and reporting under the Physician Quality Reporting Initiative ("PQRI") and RHQDAPU programs. The NQF, a leader in endorsing consensus-based quality measures, will be convening a HIT utilization expert panel this spring to explore the feasibility and effectiveness of automated HIT measurement in EHR utilization. The knowledge generated from the panel will be published in a report. Subsequently, the NQF plans to announce an "Intent to Call for Candidate Standards," followed by an NQF consensus development process project for measures of effective HIT usage. This project will be critical in advancing evidence-based measures of HIT utilization that should form the basis of future functional measures of meaningful use. Until evidence-based HIT utilizations measures have been endorsed by the NQF, CMS should not finalize any policy on the topic. Instead, CMS should take under advisement the comments made by experts and providers related to the burden associated with the measures of meaningful use proposed in the Proposed Rule.

- **Measure Calculation Should be Required as Part of the EHR Certification Process**

Thirteen of the proposed hospital meaningful use objectives require the calculation of a numerator and denominator to arrive at the resulting threshold from the associated measure. The FAH is extremely concerned that the calculation of these denominators could prove very burdensome for hospitals. For example, in order to calculate the percent of orders entered using Computerized Provider Order Entry ("CPOE"), hospital staff will have to manually count the total number of inpatient orders issued during the EHR reporting period. There is currently no requirement for certified EHR systems to be capable of producing the data to measure meaningful use. The calculation for each measure should be able to be easily extracted from the EHR system and not require additional manual processes such as chart reviews. For all measures requiring a numerator and denominator, the calculation of those measures should be required as part of the EHR certification process to lessen the burden on hospitals.

- **CMS Should Not Require 100 Percent Thresholds for Meaningful Use Objectives**

For the proposed meaningful use objectives, CMS requires less than 100 percent compliance for Stage 1. The Proposed Rule indicates that these thresholds were set to "create a high standard, while still allowing room for technical hindrances and other barriers to reaching

full compliance.” However, the Proposed Rule indicates that full compliance (100 percent) is the ultimate goal.

While CMS’ acknowledgement that full compliance is not the appropriate threshold for Stage 1 is appreciated, the FAH strongly recommends that CMS not consider a threshold higher than “substantially all” for any future stage of meaningful use. Even in a fully automated care delivery environment, there could be discrete situations during which the use of a supplemental paper process may be necessary. Technology is not 100 percent reliable all of the time, and, therefore, it would be inappropriate to hold hospitals to a 100 percent threshold for any meaningful use objective as the EHR incentive program moves forward. The consequences of not meeting an absolute 100 percent standard are too great and do not further the overall policy goal of adoption and use of HIT.

#### **D. Specific Comments on Proposed Meaningful Use Objectives**

In addition to the comments offered above, we have several specific recommended modifications to the meaningful use objectives and measures as currently proposed. We also request further clarification on many of the proposed objectives and their associated measures.

The FAH has a number of concerns with the CPOE objective and its related measure as currently structured, including the burden associated with calculating the measure’s denominator and the exclusion of orders originating in the Emergency Department (ED) for patients subsequently admitted to the hospital within three days, when these services are covered under the inpatient payment, from the CPOE threshold. We are further concerned that the objective, in requiring use of CPOE for orders “directly entered by authorizing provider,” does not account for instances when a scribe, such as a nurse or physician assistant, may be necessary. Our specific comments on this objective are included in the table below.

In general, the FAH supports the inclusion of criteria that require the testing of health information exchange capabilities. While testing these capabilities will require investment in electronic interfaces, we believe that meaningful use should promote the advancement of interoperability over time. We appreciate CMS’ recognition of the limited information exchange infrastructure in place today and that a successful test will depend on the ability of both parties to connect in order to exchange the data. We believe, given the nascent state of interoperability, that testing is appropriate and meaningful use should only require exchange capabilities beyond testing once a more robust health information exchange infrastructure is in place and proven to be reliable.

**TABLE 2. RECOMMENDATIONS ON PROPOSED MEANINGFUL USE OBJECTIVES & MEASURES**

| <b>Proposed Objective &amp; Measure</b>  | <b>Clarifications</b>  | <b>Recommendations</b>  |
|--|--|---|
| <b>Use of CPOE for orders (any type) directly entered by authorizing provider;</b> | The FAH requests clarification of the denominator for this measure. CMS should specify what is included in orders of “any type.” | The FAH recommends that CMS replace the current measure with a measure that does not require a manual chart review process to calculate the |

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|---|--|--|
| <p>CPOE is used for 10% of all orders</p>   | <p>We are concerned that the objective does not account for times when scribes, such as a nurse or physician assistant, are necessary. We feel strongly that their use should be counted toward the CPOE threshold (e.g., after a surgeon has scrubbed in for surgery).</p> <p>For the purposes of calculating this measure, the components of order sets should count as individual orders.</p> | <p>denominator.</p> <p><b>We support the following alternative objective:</b></p> <p>“At least 10% of unique patients have had at least one order placed through CPOE during the EHR reporting period.”</p> <p>Further, we strongly recommend that orders placed in the ED for patients that are subsequently admitted within three days count toward the CPOE threshold when these services are covered under the inpatient payment.</p> <p>Require calculation of the measure as part of the certification process for EHR technology.</p> |
| <p><b>Implement drug-drug, drug-allergy, drug-formulary checks;</b></p> <p>The eligible hospital has enabled this functionality</p> | <p>The FAH recommends that CMS make a distinction between clinical and efficiency objectives.</p> <p>Drug-drug and drug-allergy checks happen in both pharmacy information systems and as part of CPOE. Currently, these checks often occur in the pharmacy which we believe greatly advances medication safety efforts.</p>   | <p><b>The FAH recommends creating two separate measures:</b></p> <p>“Hospital has implemented drug-drug and drug-allergy checks (clinical)”</p> <p>“Hospital has implemented drug-formulary checks (efficiency)”</p>   |

|   |  |  |
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| <p><b>Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT;</b></p> <p>At least 80% of all unique patients admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data.</p>  | <p>Traditionally, the coding of problem lists has occurred at a later stage by professional coders, not at the point of care in order to mitigate disruptions to workflow.</p> <p>CMS should clarify what is meant by the terms “maintain” and “up-to-date.”</p>   | <p><b>The FAH recommends the following modifications:</b></p> <p>Require a code selection or walk-through function as part of the associated certification criterion for the EHR.</p> <p>Require calculation of the measure as part of the certification process for EHR technology.</p>   |
| <p><b>Record Demographics (preferred language, insurance type, gender, race, ethnicity, date of birth, date and cause of death in the event of mortality);</b></p> <p>At least 80% of all unique patients admitted to the eligible hospital have demographics recorded as structured data</p>   | <p>All fields may not be complete for all patients. For example, a patient may not be willing to report his or her race. Recording demographics must account for patient preferences.</p> <p>The coroner determines cause of death and therefore the timeframe for obtaining this information may not be within the control of the hospital.</p>   | <p><b>The FAH recommends the following modifications:</b></p> <p>Require calculation of the measure as part of the certification process for EHR technology.</p> <p>Remove cause of death</p> <p>Allow records with indication that the information was “not provided” by the patient for any demographic field to count toward the numerator.</p> |
| <p><b>Record and Chart Vital Signs (height, weight, blood pressure, calculate and display BMI, plot and display growth charts for children 2-20 years)</b></p> <p>For at least 80% of all unique patients age 2 and over admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20</p> | <p>In the inpatient setting, estimated or reported height could be recorded.</p> <p>Other vital signs may be more appropriate to the inpatient setting, such as temperature, blood oxygen levels, heart rate, and glucose levels. EHRs should be capable of showing trends for these values.</p> <p>All fields may not be complete for all patients. This should not disqualify a patient from the numerator for this measure.</p> | <p><b>The FAH recommends the following modifications:</b></p> <p>CMS should either allow records missing one or two fields to be included in the numerator or “unpack” this objective into separate criteria.</p> <p>Require calculation of the measure as part of the certification process for EHR technology.</p>                               |

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| <p><b>Record Smoking Status for Patients 13 or Older;</b></p> <p>At least 80% of all unique patients 13 years or older admitted to the eligible hospital have “smoking status” recorded</p>   | <p>This objective does not include a definition of “smoking status.” Consistency in data definitions is necessary to ensure information collected can be utilized across EHR and quality reporting programs.</p>  | <p>The definition of “smoking status” for this objective should be consistent with the smoking cessation quality measure under the RHQDAPU program.</p>   |
| <p><b>Report Hospital Quality Measures to CMS or the States</b></p>   | <p>See “Reporting Clinical Quality Measures”(Section III)</p>   | <p>See “Reporting Clinical Quality Measures” (Section III)</p>  |
| <p><b>Incorporate Clinical Lab-Test Results into EHR as Structured Data;</b></p> <p>At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</p> | <p>The measure is poorly specified. It requires specific definition of tests that are positive/negative and in numeric format.</p> <p>Automated measurement would require indicators in the EHR for when a result is in positive/negative or numerical form.</p> <p>This objective requires structured lab data but there are currently no rules for external laboratories to be compliant.</p> | <p><b>The FAH supports the following alternative objective:</b></p> <p>At least 50% of all clinical lab tests (processed within the hospital) incorporated into the EHR whose results are in a positive/negative or numerical format are incorporated into certified EHR technology as structured data</p> <p><b>We also recommends the following modifications:</b></p> <p>Exclude external labs from the measure calculation</p> <p>Require calculation of the measure as part of the certification process for EHR technology.</p> |
| <p><b>Check Insurance Eligibility Electronically from Public and Private Payers;</b></p> <p>Insurance eligibility checked electronically for at least 80% of all unique patients admitted to the eligible hospital</p>  | <p>Including this objective would require either (1) long-standing administrative systems to be certified or (2) this function to be performed using a certified EHR.</p> <p>While generally integrated, administrative systems are not commonly part of the hospital EHR system.</p>   | <p>The FAH recommends that this objective be removed from the definition of meaningful use.</p>   |

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|  | This function is included in the HIPAA administrative simplification regulations.   |  |
| <p><b>Submit Claims Electronically to Public and Private Payers;</b></p> <p>At least 80% of all claims filed electronically by the eligible hospital</p>   | <p>Including this objective would require either (1) long-standing administrative systems to be certified or (2) this function to be performed using a certified EHR.</p> <p>While generally integrated, administrative systems are not commonly part of the hospital EHR system.</p> <p>This function included in the HIPAA administrative simplification regulations.</p>   | The FAH recommends that this objective be removed from the definition of meaningful use.   |
| <p><b>Provide Patients with an Electronic Copy of their Health Information, Upon Request;</b></p> <p>At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours</p> | <p>Use of portable media presents security concerns for the hospital including both security of protected health information on the portable media and security of the hospital's technology systems.</p> <p>The time period is more proscriptive than the HIPAA requirements. Clinicians must review information and ensure they have received all test results and discussed sensitive results with the patient before release.</p> | <p><b>The FAH recommends the following modifications:</b></p> <p>Revise objective to be consistent with HITECH privacy provision (electronic copy of health information "maintained in electronic form").</p> <p>Remove time requirement to be consistent with existing HIPAA policies.</p> <p>Require calculation of the measure as part of the certification process for EHR technology.</p> |
| <p><b>Perform Medication Reconciliation at Relevant Encounters and Each Transition of Care</b></p> <p>Perform medication</p>   | <p>CMS should clarify what is meant by "relevant" encounters and the manner in which the reconciliation must be performed. The proposed measure does not indicate that hospitals are required to do this electronically.</p>  | <p>Require calculation of the measure as part of the certification process for EHR technology.</p>   |

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| reconciliation for at least 80 percent of relevant encounters and transitions of care   |   |   |
| <p><b>Protect Electronic Health Information Maintained Using Certified EHR Technology through Implementation of Appropriate Technical Capabilities;</b></p> <p>Conduct or review a security risk analysis and implement security updates as necessary</p> | See “Privacy & Security” Comments Below | See “Privacy & Security” Comments Below |

### E. Privacy & Security

The Proposed Rule contains a Stage 1 objective to protect electronic health information created or maintained by the certified EHR technology through implementation of appropriate technical capabilities. In discussing this objective, CMS indicates that the agency does “not believe meaningful use of certified EHR technology is the appropriate regulatory tool to ensure such compliance with the HIPAA Privacy and Security Rules.” The FAH agrees that the meaningful use requirements should not be used to ensure compliance with the HIPAA Privacy and Security Rules.

The FAH strongly supports the protection of all patient data, either through privacy protections or security requirements. We note that HIPAA compliance is already mandatory for all hospitals and is enforced by the Office of Civil Rights (“OCR”), which has various sanctions available to address non-compliance in these areas. Thus, CMS should not assume duplicative enforcement powers over these regulatory policies simply because this objective is part of meaningful use. In fact, such an approach would be inconsistent with the recent delegation from CMS to the OCR regarding enforcement of the HIPAA Security Rule, which recognizes, among other things, the importance of a single agency structure for compliance purposes.

Instead, CMS should recognize that the Stage 1 measure of “conduct[ing] or review[ing] a security risk analysis . . . and implement[ing] security updates as necessary” is already met through compliance with the HIPAA Security Rule. Absent a finding by the OCR that an eligible hospital is not in compliance with this particular security policy, CMS should conclude that this measure is being met by an eligible hospital for meaningful use purposes. CMS should also clarify that conducting a security risk assessment may, but is not required to, be met through the certified EHR. Hospitals that already have effective systems in place to conduct this security

assessment should not now be asked to change course due to an arbitrary policy that requires the use of “certified EHR technology.”

Moreover, we urge CMS not to use the meaningful use policy to impose different, additional, and/or inconsistent privacy and security policy requirements from those policies already required by the Privacy and Security Rules. In this regard, we are concerned about the Proposed Rule’s reference to the “fair data sharing practices set forth in the Nationwide Privacy and Security Framework,” and whether this is intended to refer to policies that may go beyond the existing privacy and security framework. While the discussion of this framework would appear to refer generally to existing privacy and security policies, it could also be interpreted as indicating additional or different requirements. CMS should address this issue directly in the final rule. If the reference to the national Framework is intended to refer to policies beyond the privacy and security policies now in effect, then we strongly urge CMS to eliminate this discussion related to this objective.

#### **F. Attestation of Meaningful Use**

The FAH supports CMS’ proposal to use attestation statements to reflect compliance with all elements of meaningful use for Stage 1, while recognizing the possibility that electronic submission of quality data may be required in 2012. We appreciate that CMS has recognized the challenge of verifying compliance through actual data transmission in the early years and struck an appropriate balance with the overall policy goal of adoption and use of EHRs as soon as possible.

While the proposed regulations provide some specificity regarding the required attestations, they also recognize that ultimately the form of the attestation will be set in a manner specified by CMS, presumably in the governing statement itself. We strongly urge CMS to adopt attestation language that allows a signatory to attest to compliance with the requirement to the best of their knowledge and belief and that they do so in good faith. Because the agency will conduct audits, CMS may determine in a particular case that it does not agree that an eligible hospital or EP satisfies the meaningful use requirements, and thus challenge a particular attestation statement. In such cases, recoupment of the incentive payments may be appropriate.

Given the complexity of the meaningful use requirements, we anticipate that there may be instances where an eligible hospital or EP attests to meeting meaningful use with the best of intentions, but could still be found to be in error. While the payment impact is clear with recoupment, hospitals are further concerned about the potential for False Claims Act exposure for making an improper attestation. (The False Claims Act imposes civil liability for when false claims or statements are made to secure payments from the public fisc.) Given the complexity around and breadth of the meaningful use policy, it would be very helpful if CMS incorporated a “good faith” standard and “to the best of my knowledge and belief” standard into its attestation statements to help mitigate unwarranted whistleblower lawsuits seeking treble damages and civil fines.

## **G. Consideration for Small Community Hospitals**

CMS solicits comments on whether certain providers may have difficulty meeting one or more of the proposed meaningful use objectives. The FAH appreciates CMS' recognition that certain providers may have unique challenges in meeting the meaningful use requirements. The FAH is concerned that small hospitals may have particular difficulty in meeting the meaningful use requirements, especially under the proposed "all or nothing" approach.

Small hospitals, especially those in rural areas, face a unique set of challenges in attempting to meet the proposed meaningful use requirements. Challenges for these providers include limited access to capital and severe HIT workforce constraints. Given that bed size is a key determinant of HIT adoption, we are concerned that holding small providers to the same level of meaningful use, especially in the early years of the program, will prevent them from accessing critical incentive payments that may be necessary for them to build functional capacity overtime.

Further, under a compressed timeline to implement certified EHR technology caused by regulatory delays, health care systems are forced to make strategic decisions prematurely about where and when to deploy new HIT systems. This could result in delayed deployment of technology to smaller hospitals to the later years of the program, placing them on a steeper incline to the final stage of meaningful use to avoid financial penalties set to begin in 2015. The potential for growth in the digital divide between small and large hospitals is great and will prevent the clinicians and patients in those communities from realizing the full potential of HIT to improve the quality, safety and efficiency of health care.

## **H. Future Direction of Meaningful Use**

As mentioned above, CMS solicits comments on the proposed 3-stage pathway for meaningful use. The Proposed Rule outlines the specific requirements for Stage 1, but only the broad goals for Stages 2 and 3. As the framework and specific objectives in the Proposed Rule map closely to the recommendations of the HIT Policy Committee, the FAH notes that it has serious concerns with aspects of the framework for meaningful use recommended by the HIT Policy Committee in June 2009.

In August 2009, the FAH submitted a comment letter to the ONC and to CMS outlining our concerns regarding the HIT Policy Committee's recommendation to tie meaningful use incentive payments to specific quality outcomes and thresholds beginning in 2013. For example, the Policy Committee recommended that HHS adopt a measure for 2013 requiring a 10 percent reduction in preventable readmissions from 2012 to qualify as a meaningful EHR user.

As stated in our August 26, 2009 letter (See Attachment):

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 HITECH 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 strongly urges CMS not to adopt the HIT Policy Committee's recommendation to tie meaningful use to provider performance on outcomes-related quality measures as the EHR incentive program moves forward.

### **III. REPORTING CLINICAL QUALITY MEASURES**

#### **A. Proposed Clinical Quality Measures for Electronic Submission by Eligible Hospitals**

CMS proposes that for the 2011 payment year hospitals use certified EHR technology to capture the data elements and calculate the results for 35 clinical quality measures to qualify for meaningful use under the Medicare EHR incentive program. While the NPRM delays reporting for hospitals only eligible for the Medicaid incentive program until 2012, hospitals participating in both programs will be subject to reporting on an additional 8 Medicaid measures in 2011. The NPRM further proposes that for the 2012 payment year, hospitals will be required to submit these measures to CMS electronically using certified EHR technology.

Hospitals have been at the forefront of efforts to measure and improve the quality of care provided to patients. The data obtained through hospital quality measurement and reporting activities have provided critical information to guide quality improvement efforts as well as information to aid consumers in making decisions about where to receive their care.

The current hospital quality measurement and reporting enterprise has grown organically over the past several years, rooted in evidence-based measures endorsed through the NQF consensus standards development process and multi-stakeholder collaboration between the public and private sectors facilitated by the HQA. As we move to a future state of electronic quality reporting, required by HITECH, we strongly recommend that CMS build on the current quality infrastructure rather than establish parallel reporting programs.

With a focus on building on the existing quality infrastructure, the FAH is pleased to offer the following comments and recommendations on the proposed meaningful use objective to report clinical quality measures to CMS and the States using EHR technology:

- **Delay Electronic Clinical Quality Reporting Until at Least 2012**

CMS solicits comment on whether it may be more appropriate to defer some, or all, clinical quality reporting until the 2012 payment year. The FAH strongly recommends that CMS defer all electronic clinical quality reporting until at least the 2012 payment year. Requiring hospitals to report summary data to CMS through attestation in 2011, absent CMS' ability to receive the data electronically, creates a dual reporting burden on hospitals for the proposed measures currently being reported through the RHQDAPU program.

We further believe that the number of measures proposed for reporting in the NPRM would place a significant burden on hospitals. The proposed measures cover a wide range of diagnoses and care processes. Staff resources are required to make the data actionable and drive the changes in practice needed to improve the quality of care. Hospitals are committed to using quality measurement to drive improvement; however, we are concerned that implementing a significant number of new measures, as proposed in the NPRM, would force hospitals to spend more time managing the reporting process and less time focused on targeted quality improvement initiatives. The focus moving forward should be on the selection of measures in clinically related sets.

In a June 19, 2009 letter to the ONC, the FAH laid out a number of implementation issues and associated recommendations related to HITECH's requirement to report clinical quality measures using EHR technology. As we stated over nine months ago, the FAH believes there is a need for a comprehensive strategy to guide the migration to electronic quality reporting that takes into consideration the robust infrastructure already in place to report quality measures through the RHQDAPU program.

- **Measures Should be Fully e-Specified and Tested For Collection By EHRs**

The FAH is eager to see a migration from chart abstraction to quality measurement facilitated by EHR technology. However, there are several implementation issues that must be resolved in order to move successfully to a future state of electronic reporting. For clinical quality measures to be reported using an EHR, measure specifications will have to be significantly simplified and measures will need to be re-specified with the technical capabilities of the EHR in mind. As chart abstracted process measures are structured today, many data elements cannot be captured even with a comprehensive EHR and chart abstraction is still

required to document exclusions. Further, there is a high frequency of changes in the specifications and interpretations of those specifications by CMS contractors. This raises questions as to whether EHR vendors have the capacity to keep up with these changes and incorporate them into the EHR without significant lag-time.

Only 15 of the 43 proposed quality measures for Medicare and Medicaid have electronic measure specifications currently available. Any measure that will be collected and reported using an EHR should be fully re-specified for collection by an EHR and undergo thorough testing to verify the validity of the new electronic measure. The FAH supports CMS' plans to test reporting of NQF endorsed stroke, Venous Thromboembolism, and Emergency Department throughput measures that were developed and specified for collection using an EHR. We believe this testing will provide valuable insight into the potential challenges associated with electronic reporting and should be thoroughly evaluated prior to requiring electronic quality reporting as part of the EHR incentive program.

- **Build Off of the Existing CMS Hospital Quality Reporting Program (*i.e.*, RHQDAPU)**

Only nine of the proposed clinical quality measures are currently being reported by hospitals through the RHQDAPU program. The FAH is concerned about the lack of alignment between the proposed quality measures for the EHR incentive program and the quality measures currently being reported through the RHQDAPU program. We strongly recommend that CMS only require quality measures under the EHR incentive program that are included in RHQDAPU and have been fully re-specified and tested for reporting using certified EHR technology. The migration to electronic reporting could begin with fully e-specified measures new to the RHQDAPU program, with ongoing efforts to re-specify existing measures overtime.

Further, the proposed quality measures in the NPRM include both inpatient and outpatient measures, yet the proposed functional objectives for meaningful use apply only to the inpatient hospital setting. There are clear and important differences between an inpatient EHR and an ambulatory EHR and these systems are often implemented on distinct adoption timelines. Given the focus of the proposed meaningful use requirements on inpatient care, it would seem logical that CMS would begin the migration to electronic reporting with inpatient quality measures, building off of the RHQDAPU program.

The FAH has specific concerns with the proposed readmission measures for heart attack, heart failure, pneumonia, and the proposed all-cause readmission index. These measures are not NQF-endorsed and HQA-adopted and are not currently specified for collection using EHR technology. Using EHR technology, a hospital could only capture when a patient is discharged and readmitted to the same facility, which would represent a departure from the 30-day all cause risk standardized readmission measures currently reported on *Hospital Compare* through the RHQDAPU program. The current readmission measures are calculated based on a rolling three years of Medicare claims data and compared against the national average to determine whether a hospital is above, below, or the same as the national average.

## **B. Reporting Method for 2011 Payment Year**

The FAH strongly recommends that CMS defer all electronic clinical quality reporting until at least the 2012 payment year. Any measures required under the EHR incentive program should be fully e-specified and adequately tested to ensure the validity of the electronic measure. Further, we believe strongly that there should be full alignment with the RHQDAPU program to avoid dual reporting requirements. CMS should therefore only require electronic reporting of e-specified measures that are, or will be, included in the RHQDAPU program. The migration to electronic reporting could begin with fully e-specified measures new to the RHQDAPU program, with ongoing efforts to re-specify existing measures overtime.

## **C. Reporting Method for 2012 Payment Year**

For 2012, CMS proposes that in instances where a quality measure is included in the Medicare EHR incentive program and other Medicare quality reporting programs (*i.e.*, RHQDAPU), a hospital would only need to report the measure under the Medicare EHR incentive program to satisfy the parallel reporting requirement. While we believe it is critical that hospitals not be required to report quality measures under multiple programs, it is critical that any quality data used for public reporting on *Hospital Compare* be held to the same high standards of data quality and completeness that we have in the RHQDAPU program. The FAH recommends that CMS use the RHQDAPU program as the foundation for the migration to electronic quality reporting.

There are currently specific areas of disconnect between the current RHQDAPU reporting program and the quality reporting processes proposed in the NPRM. Two major areas that need to be aligned to ensure a successful migration to electronic reporting using an EHR are the level of reporting (*i.e.*, patient-level vs. aggregate level) and the reporting periods for each program. RHQDAPU uses patient-level data elements in addition to aggregated data while the Proposed Rule implements only aggregate-level reporting through EHRs. Patient-level data allows CMS to conduct data validation, while aggregate-level data could not be validated. We believe there is an underlying assumption being made that data extracted from an EHR is always valid, and we would caution CMS about making such an assumption, especially in light of very limited testing and analysis of quality data reported through EHRs. The FAH believes that data validation is a critical component of the RHQDAPU program and should continue regardless of the data submission method utilized for reporting quality measures. It is critical that CMS consider how the current data validation processes will need to be modified to support electronic quality reporting.

CMS also proposes to submit quality data for a period consistent with the “EHR Reporting Period,” which is 90 days for a hospital’s first payment year and the full federal fiscal year for all subsequent payment years. This is inconsistent with the quarterly reporting under RHQDAPU and would inhibit the periodic refreshing of the data on the *Hospital Compare* website. While the EHR reporting periods proposed in the NPRM may be appropriate for demonstrating meaningful use, they would represent a significant step backwards in promoting ongoing quality improvement by providers and the release of quality information to consumers.

CMS proposes three potential data submission methodologies for the 2012 payment year – a CMS-designated portal, Health Information Exchanges, and registries. We recommend that CMS select one data submission method with the goal of achieving the flow of quality information directly from the EHR to the CMS warehouse. It is critical that reporting methods be aligned for inpatient, outpatient, and EHR quality reporting. Quality reporting using an EHR should ultimately reduce the reporting burden on providers. It is therefore crucial that certified EHR technology have the capacity to calculate the quality measures without additional chart abstraction. Providers must also be able to easily extract system-generated reports out of the certified EHR.

#### **D. Selection of Quality Measures**

While the NQF has endorsed 31 of the proposed clinical quality measures, only 25 of the proposed measures have been adopted by the HQA. The FAH is a founding member of the HQA, a multi-stakeholder alliance comprised of hospitals, physicians, employers, consumers, health plans and federal government agencies that have worked closely with HHS to promote quality measurement and reporting. The HQA plays a critical role in assessing the readiness of NQF-endorsed quality measures for implementation by hospitals for public reporting and quality improvement.

The FAH is steadfast in its belief that any hospital quality measure required by CMS for any quality reporting and/or payment program should be both endorsed by the NQF and adopted by the HQA. Just over a year ago, a coalition of consumers, clinicians, hospitals, employers and insurers came together to create a set of recommendations to build on the current quality measurement and reporting infrastructure. The “Stand for Quality” coalition reached consensus on six key functions:

- Set national priorities and provide coordination
- Endorse and maintain national standard measures
- Develop measures to fill gaps in national priority areas
- Engage in effective consultative process so stakeholders can inform policies on use of measures
- Collect, analyze and make performance information available and actionable
- Support a sustainable infrastructure for quality improvement

Stand for Quality underscores the broad support for an effective stakeholder consultation process on the selection of quality measures, based on national priorities, prior to those measures being included in rulemaking. This type of public-private collaboration is necessary to ensure that all elements of the quality measurement and reporting enterprise are working toward the same goals of improving patient care with a shared understanding of where implementation challenges may lie.

#### **IV. HOSPITAL-BASED ELIGIBLE PROFESSIONAL**

Under the meaningful use policy, incentive payments are also available to qualifying “eligible professionals.” Excluded from such category are hospital-based professionals, who are

defined as those who furnish substantially all of their services in a hospital setting (whether inpatient or outpatient) using the facilities and equipment, including the EHR, of the hospital.

The Proposed Rule seeks to flesh out and define the parameters of this statutory standard. First, the FAH supports CMS's decision to define "substantially all" as at least 90 percent of all services performed in the hospital.

However, we are concerned that the proposed policy may prevent incentive payments for eligible professionals who practice in outpatient centers or clinics that may be affiliated with a hospital, but do not necessarily use the hospital's facilities and equipment. First, there are clear and important differences between an inpatient EHR and an ambulatory EHR. Just because a hospital has implemented, or plans to implement, an inpatient EHR does not mean that it will necessarily implement an ambulatory EHR for its outpatient departments and clinics or do so on the same timeline as the inpatient EHR. From a capital expenditure perspective, implementing different EHR products may be staged or alternate plans may be pursued for certain outpatient clinics.

A physician who practices in an ambulatory setting may never even use an inpatient EHR, but will rely heavily on whatever ambulatory recordkeeping system in place. In such a scenario, it is not unusual for physicians to contribute financially to the cost of an ambulatory EHR, which means under the statutory standard that they are not providing services using the hospitals' "facilities and equipment." Thus, the physician in the example should be eligible for incentive payment to encourage the adoption and use of an ambulatory EHR.

The FAH urges CMS to set final policy in a way that does not preclude incentive payments for those physicians who practice in an outpatient or clinic setting that may be affiliated with a hospital, but that does not use equipment provided by the hospital. To do otherwise would set policy that would hinder the widespread adoption of health information technology in ambulatory settings and hospital-based primary care settings.

In addition, CMS plans to use place of service codes as the sole determinant of whether an EP is hospital-based for both Medicare and Medicaid. However, we are concerned that such an approach would not be appropriate for e-prescribing situations. We believe a better approach is for CMS to revise its proposal to so that CPT codes that indicate services listed in the e-prescribing denominator are excluded from the hospital-based determination, even if they have place of service code 22.

## **V. MEDICARE INCENTIVES**

Our comments below address the FAH's hospital specific-concerns related to the administration and calculation of the Medicare incentive payments.

### **A. Medicare Administrative Contractor ("MAC") Administration of Payments and Audits**

The Proposed Rule does not address whether the administration of interim and final payments and audits and determinations under the incentive program will be the responsibility of

a single national MAC or an individual hospital's MAC. Our membership favors administration of this program by their hospital-specific MACs. The administration of this program uses cost report data for a numbers of purposes including the development of certain non-cost statistics in the case of hospitals subject to the inpatient prospective payment system ("IPPS"), and the use of cost data and non-cost statistics in the case of critical access hospitals. The use of a national MAC to administer the incentive program could result in inconsistent determinations with respect to the data in question as compared to the determinations that a hospital-specific MAC will make to settle cost reports. Such inconsistencies will unnecessarily complicate administration of the incentive program. Hospital-specific MACs have far greater familiarity with the data that such hospitals are reporting and must be used to administer the incentive program. Based on the foregoing we request that CMS use hospital-specific MACs to administer this program.

### **B. The Timing of Interim Incentive Payments**

While the Proposed Rule at 42 C.F.R. § 495.104(c)(3) does address the calculation of interim payment amounts for hospitals under IPPS, it does not address when and how such payments will be made. These are very important factors to hospitals that are making significant investments in EHR technology now, well before they are determined meaningful users of such technology. It is therefore critical that CMS develop procedures to make interim payments available to eligible hospitals as quickly as possible in lump sum form, as authorized by HITECH.

FAH members favor a lump sum interim payment to help reimburse expenditures as soon as possible. We propose that a hospital in year one of its participation in the incentive program be paid within 15 days after filing its attestation of 90 consecutive days of meaningful use. The preamble indicates there is a presumption of meaningful use after the first year attestation: "it is unlikely that they would adjust their behavior just because the EHR reporting period has ended." *See* 75 Fed. Reg. at 1849 col. 3. Such presumption should continue until an audit indicates the contrary or a provider fails to file its next attestation when due. Consequently, each subsequent interim payment should be made within thirty days of the beginning of each subsequent payment year. However, to accommodate these expeditious payments, CMS should modify section 495.104(c)(2) to allow for the use of the most recent filed cost report available to make such interim payments, instead of the current proposal to use the cost report from the year preceding the payment year, which might not be available until 150 days after the beginning of the payment year. In the event CMS disagrees with our proposal to use the most recently available cost report, the FAH proposes that such lump sum payment occur within 15 days of the filing of a hospital's cost report for the year preceding the applicable payment year.

### **C. Non-Standard Cost Reporting Periods**

Both Congress and CMS expect that during the course of the incentive program the vast majority of hospitals will become meaningful users of EHR technology. Given the number of hospitals that are expected to participate in the program the FAH was surprised that neither section 495.104 or the commentary accompanying the Proposed Rule address how the program will be implemented for hospitals that experience non-standard cost reporting periods either for a payment year or for the period that will be used for interim payment data. We expect that while

such situations will not be common they will nonetheless be sufficiently frequent that protocol should be established in the regulations. We expect these situations will arise in three instances: (1) newly constructed hospitals; (2) changes of ownership; and (3) the reorganization of single provider multi-campus hospitals into multiple separate providers.

For purposes of example and discussion our members have focused on the following example and situations:

- A newly constructed hospital commences operations as a subsection (d) provider on August 1, 2010;
- On October 1, 2010, the hospital begins to meaningfully use its certified EHR technology and has 90 continuous days of qualifying meaningful use on December 31, 2010;
- The hospital's first fiscal period is a short period that ends December 31, 2010, because it wishes to have a cost reporting period consistent with other members of its system. Thus, its next cost reporting period will commence January 1, 2011 and end December 31, 2011, during federal fiscal year 2012;
- The hospital certifies 90 days of continuous meaningful use to its MAC on January 15, 2011 for federal fiscal year 2011.

Under the Proposed Rule there is no provision for a period that could be used to calculate interim payments for this provider, nor is there a twelve-month period that could be used to derive the data necessary for final settlement. Nonetheless, the provider has 90 continuous days of meaningful use in federal fiscal year 2011.

Similar to the example above, a subsection (d) hospital may be sold during the incentive program resulting in a short period cost report during a given federal fiscal year under the incentive program. Unlike the example above, in this situation, a preceding and a subsequent full fiscal year cost report are available for purposes of determining interim and final payment.

Finally, during the incentive program, a single multi-campus provider is split as a result of a change of ownership in part of the original provider, resulting in two providers both of which would operate differently in the current period. In the case of the new provider, just like a newly constructed hospital, it would have no cost report under the Proposed Rule to use for interim payment purposes. In the case of the remaining provider, the prior period cost report would not reflect operations during the current incentive payment year.

To account for these situations, we suggest three changes to the proposed regulation at section 495.104(c)(2), as set forth in the italicized language below:

(2) Interim and final payments. *Except as provided in subparagraphs (i) - (iii) below, CMS uses data on hospital discharges (as that term is defined in § 412.4(a) of this chapter), Medicare Part A inpatient-bed days, Medicare Part C inpatient-bed days, and total inpatient-bed-days, from the hospital cost report for the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year*

that serves as the payment year as the basis for making preliminary incentive payments. Final payments are determined at the time of settling the hospital cost report for the hospital fiscal year that ends during the payment year, and settled on the basis of data from that cost reporting period.

*(i) Short Period Cost Reports for Interim Payment Purposes - If a hospital cost report period that ends in a Federal fiscal year used for interim payment purposes is less than twelve (12) months, CMS shall use cost report data, as noted §495.104(c)(2), from the first full year hospital cost report that precedes such short period. In the event no such full year prior period report is available for a new hospital, budgeted data from such hospital shall be used for interim payment purposes;*

*(ii) Short Period Cost Reports for Final Payment Purposes - If a hospital cost report period that ends in a Federal fiscal year used for final payment purposes is less than twelve (12) months, CMS shall use cost report data, as noted §495.104(c)(2), from the first full year hospital cost report subsequent to such short period;*

*(iii) Petition to CMS Regional Office – A hospital may petition the CMS Regional Office responsible for its jurisdiction for a remedy in those situations not foreseen in the above subparagraphs.*

The FAH greatly appreciates CMS' consideration and response to our example and proposed amendments above. Additionally, we note there appears to be an error in subsection 495.104(b)(5). The last date appearing in that subsection is stated as "2017" and we believe that date should be "2016."

#### **D. Charity Care Data**

Worksheet S-10 revisions by CMS are not complete, 75 Fed. Reg at 1913, col.3, yet CMS indicates the form will be used for periods beginning on and after Feb. 1, 2010. Even as indicated, this will not occur in sufficient time for the data necessary for interim payments, and in some cases, final payments for periods that end December 31, 2010 for Year 1. The FAH would appreciate an explanation of how CMS proposes to bridge this gap. We propose that hospitals report the data in question using the current draft of Worksheet S-10 or on a separately supplied report from hospitals using the same data.

We believe CMS incorrectly indicates that Medicare does not reimburse for charity care: "For Medicare purposes, charity care is not reimbursable, and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt." 75 Fed. Reg. at 1913, col. 3. That statement is inconsistent with PRM – I § 312 wherein the Medicare program reimburses as bad debt the coinsurance and deductible amounts that apply to patients that qualify under a hospital's charity care policy.

## **E. Incentive Payment Calculation for Eligible Hospitals**

### **1. Discharges**

The FAH requests that CMS identify the source(s) of the discharge data it plans to use to compute the total discharges for purposes of determining the Discharge Related Amount. Providers need to know the source of the discharge data if they are to be able to adequately comment on the adequacy of, or any other issues regarding, the data or its sources. Further, although not entirely clear, the FAH would like to make certain that for purposes of the Discharge Related Amount, no type of discharge, regardless of the source of payment, will be excluded from the count, including nursery discharges and discharges in non-IPPS areas of the hospital. The statute clearly requires the inclusion of all inpatient discharges regardless of type of patient or location of the patient within the inpatient areas of the hospital. See 42 U.S.C. § 1395ww(n)(2)(C) and (D) (requiring that the discharge related amount “shall be determined ... based on the *total discharges of the eligible hospital*” and that the Medicare share uses inpatient bed days “attributable to individuals with respect to whom *payment may be made under part A* ....”

### **2. Medicare Share – IPPS and Nursery Days**

For purposes of the Medicare share, CMS appears to be proposing to count only patient days associated with IPPS areas of the hospital and to exclude nursery days (as it does for its approach to direct graduate medical education (“GME”)). The exclusion of non-IPPS or nursery days is inconsistent with the statute, 42 U.S.C. § 1395ww(n)(2)(D), which requires the inclusion of all inpatient days “attributable to individuals with respect to whom payment *may* be made under part A. . . .” This statutory language clearly and broadly encompasses the inclusion of all inpatient days associated with Medicare eligible patients without restriction based on the type of part A patient or the area of the hospital involved in the inpatient care. Simply, there is no basis in the statutory language to exclude inpatient days associated with non-IPPS areas of the hospital. Significantly, the EHR incentive payment is not an IPPS add-on like GME, and, thus, CMS should not be limiting the computation of the Medicare Share to IPPS days as it does in the GME context. Essentially, once a hospital is eligible for the incentive payment, Congress’s clearly expressed intent is to encourage EHR adoption throughout all inpatient areas of the hospital. Nothing in the statute suggests that Congress would want to limit the measure of a qualifying hospital’s Medicare utilization to just IPPS and non-nursery patient days.

Also, it seems that CMS’s detailed instructions on the calculation of days is inconsistent with its statement that patient days will only be counted if they are in IPPS areas of the hospital. The detailed instructions indicate that line 14 from Worksheet S-3, part 2 should be utilized in determining days. This line and its subscripts, however, include IPPS-exempt units such as IPFs and IRFs. Regardless, as noted above, the FAH believes that the days for all such inpatient units should be included in the Medicare Share computation.

### **3. Medicare Share - Paid versus Unpaid Medicare Days**

For purposes of the Medicare share, CMS also appears to be proposing to use only paid Medicare days. The FAH strongly believes that all eligible Medicare days should be counted in order to accurately reflect a hospital's true Medicare utilization. Again, as noted above, the statute plainly requires the inclusion of all days where a patient was eligible for payment by Medicare. Congress knows how to limit a count to just paid days. *See* 42 U.S.C. § 1396b(t)(5)(C) (Congress limiting inclusion of Medicaid managed care days in the Medicaid Share to paid days). Congress instead used the much broader language requiring inclusion of all days associated with individuals "with respect to whom payment *may* be made under part A . . . ." Such language does not require actual payment by Medicare. Indeed, Congress in the very next provision requires the inclusion of all patient days associated with individuals enrolled in a part C Medicare Advantage plan. 42 U.S.C. § 1395ww(n)(2)(D)(i)(II). There would be no rational basis for Congress to include all enrolled part C days, quite clearly regardless of whether they are paid, but to limit part A days to those paid by Medicare. And, in fact, Congress did not do so.

#### **F. Appeal Rights**

While there are limitations on certain appeal rights under HITECH, some matters, such as the selection and audit of data by a MAC for purposes of final payment, will be subject to appeal. Unfortunately, the Proposed Rule does not address the kind of notice that will be provided by a MAC that will form the basis for such an appeal nor the applicable procedures. The payments involved here do not appear to be items settled through a notice of program reimbursement for a given hospital fiscal period. Providing a separate EHR incentive program final payment notice with appeal instructions will assist in avoiding confusion in the appeal process.

#### **G. Cost Report Data Issues**

A review of HCRIS data for cost reports ending in calendar year 2008 indicates that the majority of IPPS hospitals have not reported Medicare HMO days on line 2 column 4 of Worksheet S-3 Part 2. Based on December 31, 2009 HCRIS data only 1,443 of the 3,592 IPPS facilities, just forty percent, reported these days. This is likely because reporting such information will only have a payment consequence for hospitals with teaching programs. Hospitals should be allowed to amend their cost report and or provide corrected information to the MAC for the interim payment calculation. CMS should alert MACs and hospitals as to the importance of this information for cost reports that will be utilized for the final calculation of these incentive payments.

#### **H. Payment Accounting Under Medicare**

The Proposed Rule indicates that CMS will conduct compliance reviews of, among others, eligible hospitals that receive incentive payments focusing on validation of provider eligibility and their attestations. CMS indicates that it will recoup any identified overpayments related to an incorrect or fraudulent attestation or other required submission. We understand the need for CMS to conduct compliance reviews, and do not oppose such activity. However, the Proposed Rule directs eligible hospitals to maintain record on meaningful use for 10 years, which seems like an excessive timeframe, especially when you consider that the documentation retention period is actually twice the timeframe of the incentive payments themselves.

The FAH urges CMS to limit the timeframe that eligible hospitals must maintain such documentation to no longer than three years after the date a hospital indicates it qualifies with the standards applicable for a particular stage of meaningful use.

## **VI. MEDICAID INCENTIVES**

Our comments below address the FAH's hospital-specific concerns related to the administration and calculation of the Medicaid incentive payments.

### **A. Medicaid Patient Volume**

We address below two issues related to the calculation of Medicaid patient volume. First, under the Proposed Rule, a hospital is required to elect the state from which it will receive its Medicaid component of incentive payments. We request that CMS clarify that for purposes of establishing Medicaid patient volume under proposed 42 C.F.R. § 495.306, and the Medicaid share, the count of Medicaid days includes patients from any state's Medicaid program, not just the state responsible for payment. When Congress adopted Social Security Act § 1903(t), it defined minimum patient volume for qualification as an eligible hospital to include services provided to needy individuals, which under section 1903(t)(3)(F):

The term 'needy individual' means, with respect to a Medicaid provider, an individual—

- (i) who is receiving assistance under this title;
- (ii) who is receiving assistance under title XXI;
- (iii) who is furnished uncompensated care by the provider; or
- (iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

This definition is extremely inclusive and would include all Medicaid beneficiaries irrespective of their responsible state Medicaid program.

Second, the calculation of the ten (10) percent patient volume threshold attributable to Title XIX for a hospital to qualify for an incentive payment under Medicaid, 42 U.S.C. § 1396b(t)(2)(B)(ii), also provides the Secretary with discretion in calculating such patient volume. We believe such calculation should consider charity care and the other items included in our Comment E.2. above in the same fashion as it is used in the Medicare and Medicaid share calculations. This could be accomplished by reducing total discharges, days or encounters attributable to charity care just as they are addressed in the share calculations. The failure to account for charity care in this way could harm hospitals that have high levels of charity care by making them ineligible for the Medicaid incentive payments.

Below is an example of how this calculation would work. A hospital with nine (9) percent Medicaid utilization and ten (10) percent charity utilization would not qualify if this is not considered, but would if the numerator was reduced in the same way it is for the calculation of the Medicare and Medicaid share.

|                                     |             |
|-------------------------------------|-------------|
| Medicaid Encounters                 | 900         |
|                                     |             |
| Total Encounters                    | 10,000      |
|                                     |             |
| Percentage of Total Encounters      | 9.0%        |
|                                     |             |
| Patient Revenue                     | 100,000,000 |
|                                     |             |
| Charity Care                        | 10,000,000  |
| Patient Revenue less Charity        | 90,000,000  |
|                                     |             |
| Encounters Discounted for Charity   | 9,000       |
|                                     |             |
| Percentage of Discounted Encounters | 10.0%       |

### B. Medicaid Share – Paid versus Unpaid Days

CMS appears to be proposing to include only paid Medicaid days for purposes of the Medicaid Share computation. The FAH is concerned because CMS suggests that it will count only those days that would count as inpatient days for Medicare purposes. 75 Fed. Reg. at 1938, col. 2. First, Congress clearly indicated which types of Medicaid days to use and did not suggest in any way to rely on the Medicare Share formula when it comes to the count of Medicaid days. 42 U.S.C. § 1396b(t)(5)(C). Rather, Congress indicated the Medicaid Share should be computed in the same manner as the Medicare Share except that it then specified precisely which Medicaid days should go into the numerator. Thus, Congress’s specificity prevents CMS from relying on the Medicare Share definition of days for purposes of counting Medicaid Days. Of course, the FAH has already noted above why it believes that the Medicare Share statute is written much more broadly than CMS’s proposed interpretation. Second, the Medicaid Share statute requires the inclusion of all patient days for individual “who are receiving medical assistance” under title XIX (Medicaid). *Id.* This statutory language clearly indicates that all patients receiving medical assistance under Medicaid shall be counted for purposes of the Medicaid Share computation. This statutory language in no way limits the days to paid days. Again, Congress knows how to limit a count of days to paid days, as it has done with respect to Medicaid managed care days. *See* 42 U.S.C. § 1396b(t)(5)(C).

Importantly, as CMS knows, there is a long line of cases requiring the inclusion of unpaid but eligible Medicaid days for purposes of DSH. *See, e.g., Jewish Hosp., Inc. v. Secretary of Health & Human Servs.*, 19 F.3d 270, 284 (6th Cir. 1994) The language of the DSH statute and the language in the HITECH Medicaid Share statute are quite similar. The DSH statute refers to patients eligible for medical assistance under a state plan (42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)) and the HITECH statute refers to patients receiving medical assistance. Notably, neither statute

references payment and both merely require that the patient be Medicaid eligible. That is, a patient cannot be receiving medical assistance under title XIX if that patient is not at least eligible for medical assistance under a state plan. Essentially, using slightly different language, the DSH and HITECH statutes both broadly require the inclusion of all eligible Medicaid days regardless of payment. If Congress wants to compute a hospital's Medicaid utilization, there would be no good policy rationale for excluding the most costly Medicaid patient days from the computation, i.e., those days were the hospital is essentially providing free care with no realistic chance of any reimbursement. Further, CMS should be including as many Medicaid eligible days as possible in order to protect safety net hospitals, consistent with Congress's clear intent with the inclusion of charity care in the computation. Indeed, as CMS knows, state budget difficulties nationwide are leading to hospitals' being faced with an increasingly large population of Medicaid eligible but unpaid days. Finally, as a practical matter, many hospitals already compile and report all Medicaid eligible days (paid and unpaid). This would make it administratively seamless to identify all eligible Medicaid days.

### **C. Administrative Simplification**

Providers that demonstrate Medicaid utilization equal to or greater than ten percent in terms of discharges or days based on the latest cost report should not be required to file an attestation that they have Medicaid utilization at such level based on encounters. Attestation should be reserved for matters not covered by reported data such as providers that have higher Medicaid utilization in their outpatient areas.

### **D. Eligibility of CAHs for the Medicaid Incentive Program**

For purposes of the Medicaid EHR incentive payment program, 42 U.S.C. § 1396b(t)(2)(B) defines an eligible hospital as either:

- (i) a children's hospital, or
- (ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

CMS proposes to define an acute-care hospital as a health care facility where the average length of patient stay is 25 days or fewer, and that has a Medicare CCN that has the last four digits in the series 0001 through 0879. 75 Fed. Reg. at 1930

These CCN numbers encompass short-term general hospitals and the 11 cancer hospitals in the United States, but not CAHs because all CAHs have a Medicare CCN with the last four digits in the series 1300 through 1399. However, under section 1396b(t)(2)(B) CAHs are, by definition, general, acute-care hospitals. Even under the CMS definition such hospitals are general acute care hospitals with an average length of patient stay of 25 days or fewer. Thus, CAHs meet both the HITECH definition of being acute-care hospitals, as well as CMS's proposed definition of being short-term general hospitals. Accordingly, we urge CMS to revise

its definition of hospitals that are eligible for Medicaid payment incentives so as to also include hospitals with a Medicare CCN that has the last four digits in the series 1300 through 1399.

## **VII. CMS SHOULD PURSUE LEGISLATION TO EXPAND HITECH INCENTIVES TO ALL HOSPITAL CATEGORIES**

Any comprehensive payment reform cannot be successful if the technological levels and ability to provide/transfer patient information substantially differs within the continuum of hospital acute and post-acute care. By omitting post-acute hospitals from the health IT incentive program, Congress is creating a two-tier hospital system and missing an important opportunity to improve patient health, continuity and care coordination.

Electronic medical records significantly enhance patient safety protections for post-acute patients and ensure the same hospital level of protection in avoiding medical errors (*e.g.* abnormal lab results, dangerous drug interactions, dosing errors). Further, communication and coordination between the acute and post-acute hospital is critical to ensure a seamless transition for the patient.

Not only is this omission inequitable, but this exclusion would be a missed opportunity to improve patient care that could cost the health care system significantly more in the long run. Including acute, rehabilitation and long-term care hospitals in health IT platforms would permit these providers to work together to strengthen the health care infrastructure and achieve better outcomes for Medicare patients. For these reasons, the FAH recommends that CMS pursue legislation, with appropriate timelines and funding levels, to expand HITECH incentives to all hospital categories.

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The preceding comments reflect dozens of conference calls, meetings, and discussions with the FAH membership to develop and offer recommendations on ways to strengthen the EHR incentive program. The FAH and its member hospitals strongly support advancing the adoption and use of interoperable HIT which we believe to be the fundamental goals of the HITECH Act.

We are confident that over time, if requirements for meaningful use are appropriately phased-in, health information exchange infrastructure is built, and measures are fully specified and tested to support electronic quality reporting, we will see the improvements in quality, safety and efficiency that we are striving for. While there are numerous challenges to overcome in the years ahead, the federal government's investment in HIT presents a tremendous opportunity to assist in the transformation of our health care system for clinicians, hospitals and, above all, for patients.

The FAH looks forward to working with CMS and the ONC as implementation of the HITECH EHR incentive program moves forward. We appreciate the opportunity to submit our comments. If you have any questions regarding our comments or need additional information, please contact me or Samantha Burch of my staff at 202-624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Virginia", written over a horizontal line.

**Attachment:** August 26, 2009 FAH Comment Letter on Scope of Meaningful Use