National Association of Public Hospitals and Health Systems

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May 7, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-0044-P: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2 Proposed Rule

Dear Ms. Tavenner,

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to comment on the above-cited proposed rule. NAPH strongly supports the Centers for Medicare & Medicaid Services' (CMS') efforts to make it easier for providers to qualify for the Medicaid Electronic Health Record (EHR) Incentive Program. Several of CMS' proposals will give safety net providers valuable financial assistance as they implement the health information technology (HIT) tools needed to improve the quality of care for our nation's most vulnerable patients. However, when finalizing stage 2 meaningful use requirements, NAPH asks CMS to consider the unique challenges safety net hospitals face in implementing HIT. Safety net hospitals serve vulnerable patient populations and operate expansive systems with limited resources. These underlying factors create real, tangible obstacles to achieving certain aspects of meaningful use.

NAPH represents the nation's major metropolitan-area safety net hospitals and health systems that share the common mission of providing access to high-quality health care for all patients regardless of ability to pay. Our members predominantly serve vulnerable patients with complex medical issues. These low-income patients are primarily uninsured or covered by public programs—18 percent of the inpatient services provided by NAPH members are to uninsured patients, another 36 percent to Medicaid beneficiaries, and 24 percent to Medicare recipients. On average, 58 percent of patients seen by NAPH member hospitals are racial or ethnic minorities. And more than 100 languages are spoken by patients at NAPH member hospitals.[1]

Research has shown that socioeconomic factors—education, income level, employment, insurance status, and housing status—can have a significant impact on health outcomes.

[1] NAPH Hospital Characteristics Survey, 2010.

Individuals of lower socioeconomic status tend to be less healthy, have a higher prevalence of unhealthy behaviors (e.g., smoking, physical inactivity, poor diet, and substance abuse), and are more likely to have multiple comorbidities than those of higher socioeconomic status.[2,3,4] These patients are also less likely to have access to technology or be well-versed in how to use it. And, they also often have language and cultural barriers that make any kind of communication, including electronic, more challenging.

NAPH members have had to learn how to provide care as efficiently as possible to vulnerable patients. And they have found that providing high-quality care and eliminating health care disparities are key steps to achieving this goal. According to a recent NAPH survey, all members have a committee that oversees quality improvement activities, and all have developed plans to improve specific quality measures, including targeted plans to eliminate racial and ethnic health care disparities. Additionally, our members recognize that physician and leadership engagement are integral to achieving real improvements in the quality of care provided. As a result, almost 90 percent of NAPH members share quality performance data with their physicians, and 80 percent engage their boards of directors in quality improvement activities. Through these efforts, NAPH members have been able to effectively utilize their limited resources to improve the health of the most vulnerable patients in their communities.

In addition, as part of their quality improvement goals, some NAPH members were very early adopters of HIT and have been using it for decades. Others, however, have only recently implemented this technology. Overall, NAPH members are working diligently to become meaningful users of EHRs by investing in HIT. A recent NAPH survey found that all members are participating or plan to participate in the Medicaid EHR Incentive Program, and all but one plan to participate in the Medicare EHR Incentive Program.[5] This level of participation is higher than the 74 percent of all hospitals nationally that plan to participate in an EHR incentive program.[6]

While our members have made progress in HIT, it is essential that policymakers understand the obstacles safety net providers face in this area, to ensure our members and their patients are not left behind in the move to meaningful use. NAPH members operate on thin margins that don't allow for large-scale investments in HIT and the infrastructure necessary to support these sophisticated systems. NAPH members also have expansive outpatient clinics and hospital systems, which make systemwide implementation challenging. In addition, it is difficult to recruit a sufficient number of qualified HIT staff in many urban areas, and safety net hospitals struggle to compete financially for the personnel necessary to implement and maintain HIT systems.

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[2] Yue Chen, P. Stewart, R. Dales, H. Johansen, G. Scott, and G. Taylor, "Ecological Measures of Socioeconomic Status and Hospital Readmissions for Asthma Among Canadian Adults," *Respiratory Medicine*, Vol. 98, No. 5: 446–453 (May, 2004).

[3] Amy K. Rosen, R. Reid, A. Broemeling, and C. Rakovski, "Applying a Risk-Adjustment Framework to Primary Care: Can We Improve on Existing Measures?," *Annals of Family Medicine*, Vol. 1, No.1: 44-51 (May/June, 2003).

[4] Silvia Stringhini, S. Sabia, M. Shipley, E. Brunner, H. Nabi, M. Kivimaki, and A. Singh-Manoux, "Association of Socioeconomic Position with Health Behaviors and Mortality," *Journal of the American Medical Association*, Vol. 303, No. 12: 1159–1166 (March 24/31, 2010).

[5] 2012 NAPH HIT Issue Brief and Survey of Members.

[6] Ashish K. Jha, M. F. Burke, C. DesRoches, M. S. Joshi, P. D. Kralovec, E. G. Campbell, and M. B. Buntin, "Progress Toward Meaningful Use: Hospitals' Adoption of Electronic Health Records," *The American Journal of Managed Care*, Volume 17 (12 Spec No.): SP117-SP124 (Dec. 2011), http://www.ajmc.com/publications/issue/2011/2011-12-vol17-SP/Progress-Toward-Meaningful-Use-Hospitalsu2019-Adoption-of-Electronic-Health-Records

That said, NAPH members are not likely to meet meaningful use requirements for the first time until federal fiscal year (FFY) 2013.[7] To ensure that these safety net providers are not unfairly disadvantaged for serving the most vulnerable among us, we urge the Centers for Medicare & Medicaid Services (CMS) to consider the following comments below in finalizing the above-mentioned proposed rule.

1. CMS should finalize proposals that allow more providers to qualify for the Medicaid EHR Incentive Program.

NAPH supports CMS' proposal to expand the definition of a patient visit for the purposes of the Medicaid EHR Incentive Program for eligible professionals (EPs) and eligible hospitals. In the proposed definition, any service delivered on any day to a patient enrolled in the Medicaid program qualifies as a Medicaid patient encounter (i.e., patient visit), even if the Medicaid program did not pay for the service. Previously, if a third-party payer paid for a service for a Medicaid patient, the visit would not count toward the Medicaid patient volume requirements for eligibility for the Medicaid EHR Incentive Program. The expanded definition also includes encounters with patients enrolled in Title XXI-funded Medicaid expansion programs [i.e., Medicaid expansion programs funded by the Children's Health Insurance Program (CHIP) as opposed to separate CHIP programs].

This expanded definition would allow more providers that are appropriately serving Medicaid patients to qualify for the Medicaid EHR Incentive Program. For safety net health systems, the incentive payments received would be very helpful in facilitating the system's further adoption of HIT technology. Safety net providers are working hard to implement HIT throughout their large systems in order to improve care for their vulnerable patient populations. But they have limited resources with which to make the large infrastructure and staffing investments necessary to succeed in meaningful use. These incentive payments help to defray the significant upfront capital costs of implementing EHR systems for providers who see a significant share of Medicaid patients.

We believe the proposed changes are consistent with the Medicaid EHR Incentive Program's purpose, which is to provide incentive payments to encourage hospitals and EPs to adopt, implement, upgrade, or meaningfully use EHR technology.[8] These changes will also help the program meet its goal of increasing the adoption of EHR technology to 90 percent of physicians and 70 percent of hospitals by 2019.[9] For these reasons, CMS should finalize this proposal.

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[7] 2012 NAPH HIT Issue Brief and Survey of Members.

[8] "CMS Finalizes Requirements for the Medicaid Electronic Health Records (EHR) Incentive Program," CMS Fact Sheet, Centers for Medicare & Medicaid Services, July 16, 2010, https://www.cms.gov/apps/media/press/factsheet.asp?Counter=3793&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

[9] "Effect on federal direct spending and revenues of the Health Information Technology for Economic and Clinical Health (HITECH) Act," January 21, 2008 Letter from Robert A. Sunshine, Acting Director of the Congressional Budget Office to the Honorable Henry A. Waxman, Chairman of the House Committee on Energy and Commerce, Congressional Budget Office, U.S. Congress, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9965/hitechwaxmanltr.pdf

NAPH also recommends that CMS continue to work with states to properly distinguish patient visits for individuals enrolled in a Medicaid expansion program funded by CHIP from patient visits for individuals enrolled in separate CHIP-funded programs. Without state processes to help providers separate out these patient encounters, providers may inadvertently exclude such encounters with these low-income children in their reporting.

2. CMS should finalize proposals that add more flexibility to requirements for determining Medicaid EHR Incentive Program eligibility and incentive payments.

NAPH supports CMS' proposal to allow states more flexibility in determining the time period in which EPs and hospitals can fulfill their patient volume requirements to qualify for the Medicaid EHR Incentive Program. Under the proposed rule, states would now be able to use any 90-day period within the 12 months preceding the attestation for calculating patient volume. This proposal is in addition to current regulation, which permits states to use any 90-day period within the previous calendar year (for EPs) or fiscal year (for hospitals). State flexibility is the hallmark of the Medicaid program. As such, NAPH supports providing this additional flexibility, which will allow states to determine the most appropriate time period in which to capture significant volumes of Medicaid patients seen by eligible providers. For this reason, CMS should finalize this proposal.

NAPH also supports CMS' proposal to allow states more flexibility in determining the time period used for calculating Medicaid EHR Incentive Program payments for hospitals. Under the proposed rule, states would now be able to use the most recent continuous 12-month period for which discharge data is available prior to the first payment year. Currently, Medicaid payments are determined once, on a prospective basis, according to the hospital fiscal year that ends in the FFY prior to the first payment year. However, as noted by CMS in the preamble to the proposed rule, some hospitals may not have a full 12 months of data ending with the FFY immediately preceding the first payment year. As a practical approach to this reality, NAPH agrees with the proposed added flexibility, which will allow states to choose the most appropriate time period for determining payments. For this reason, CMS should finalize this proposal.

3. CMS should include nursery days and psychiatric unit discharges in hospital Medicaid incentive payment calculations.

NAPH disagrees with CMS' decision to retain its existing policy of excluding days spent in the nursery and psychiatric unit as eligible discharges for purposes of calculating the amount of a hospital's Medicaid incentive payments. The proposed rule stipulates that only discharges from the acute care part of the hospital can be counted when determining Medicaid EHR Incentive Program payment amounts.

In addition, NAPH members often treat newborns with significant care needs that require extended inpatient stays, and 70 percent of the newborns at NAPH member hospitals are covered

by Medicaid.[10] As well, NAPH members often treat significant populations of Medicaid (and Medicare) patients suffering from mental illness. Excluding these days is problematic because it reduces the Medicaid (and Medicare) incentive payments for safety net hospitals that are spending tremendous resources to provide care to these vulnerable newborns, who often are born with complex medical needs, and psychiatric patients. Because safety net hospitals routinely offer these kinds of comprehensive, resources-intense services, they are relying heavily on the incentives from the Medicaid EHR Incentive Program to fully fund the large capital investments needed for HIT implementation.

In addition, NAPH believes that CMS' current policy is contrary to the intent of the American Recovery and Reinvestment Act (ARRA). ARRA states that the Medicaid EHR incentive payments should be calculated in the same way as Medicare EHR Incentive Program payments, except for individuals who are receiving medical assistance under the Medicaid program.[11] Since these newborns and psychiatric patients are receiving medical assistance under the Medicaid program, the Medicaid definition of hospital services should apply. For these reasons, CMS should include days spent in the nursery and psychiatric unit in Medicaid EHR incentive payment calculations.

4. <u>When implementing the Medicare payment penalty, CMS should not effectively shorten the amount of time providers have to become meaningful users of EHR technology before the penalty is assessed.</u>

NAPH disagrees with CMS' proposal of a "look-back period," which would require hospitals to meet stage 1 of meaningful use by 2013 in order to avoid Medicare market basket reductions—reductions to the inpatient prospective payment system (IPPS) standardized amount—in 2015. Hospitals should be allowed to demonstrate they have met stage 1 meaningful use requirements in FFY 2014 in order to avoid the Medicare payment penalty in FFY 2015. In FFY 2015 and subsequent years, CMS should allow hospitals to demonstrate meaningful use requirements in the year prior to the payment penalty year and should provide a retrospective IPPS adjustment to hospitals that demonstrate meaningful use during the payment penalty year.

CMS proposes to assess Medicare payment penalties based on demonstrating meaningful use two years in advance of the payment year. CMS cites concerns about reconciling underpayments or overpayments based on whether a hospital meets meaningful use in the actual payment year (e.g., FFY 2015). However, CMS even admits that there is an existing mechanism with which hospitals can reconcile these payments—the Medicare cost report. Under CMS' proposal, even if a hospital successfully attested to stage 1 meaningful use in FFY 2011 or FFY 2012, but did not successfully attest in FFY 2013, the hospital would still incur the penalty in FFY 2015. For each year following FFY 2015, the reporting period for the payment adjustment would continue to be 2 years before the payment period.

[10] NAPH Hospital Characteristics Report, 2009, http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Characteristics-Report.aspx
[11] Section 4201(a) of ARRA, adding Section 1903(t)(5)(C) of the Social Security Act.

CMS also proposes an exception to this 2-year look-back period for those attesting to meaningful use for the first time. For these hospitals, the look-back period would be 15 months, rather than 24 months. For example, if a hospital is attesting to meaningful use for the first time, CMS would allow them to avoid the FFY 2015 penalty by attesting for a continuous 90-day reporting period that begins no later than April 3, 2014 and ends no later than June 30, 2014.

While most NAPH member hospitals will begin participating in an EHR incentive program in FFY 2012 or 2013, they are coming from diverse starting points. Some hospitals started HIT implementation from scratch within the past few years. Others have had computerized inpatient and emergency department (ED) systems for decades, but have not necessarily achieved the current definition of meaningful use. Because NAPH members are often large systems with limited resources, in general they are less likely to meet meaningful use requirements in FFY 2011 or 2012 compared to all hospitals nationwide.[12] [13] Without the resources to implement meaningful use requirements across their expansive outpatient networks and hospital systems all at once, many NAPH members are gradually implementing HIT, starting with one hospital, one inpatient unit, or a group of clinics and then gradually expanding throughout the whole system over 1 to 3 years. For safety net hospitals with extremely limited resources, any delay in payment creates a significant burden and implementation delays.

Unfortunately, some NAPH members have not been able to take advantage of the flexibility in the Medicaid program that allows hospitals to receive incentive payments by demonstrating that they are acquiring, implementing, or upgrading (AIU) certified EHR technology. These Medicaid EHR Incentive Program AIU payments are given in advance of meeting meaningful use requirements and are meant to fund upfront HIT investments for providers with limited resources who are unable to meet meaningful use requirements in their first year of program participation. However, some NAPH members reported that they were not able to receive these upfront funds in FFY 2011 because their states were either not yet operating an incentive program or not yet distributing funds. In addition, one large system saw payment delays of up to 10 months for its member hospitals.

While NAPH understands that CMS wants to avoid a situation in which it might be necessary to make large payment adjustments after the fact, it is unreasonable to implement payment penalties 2 years in advance. Under this proposal, the FFY 2015 Medicare penalty provision will be implemented in a manner that essentially moves up the deadline for meeting meaningful use to FFY 2013. Ensuring hospitals have the appropriate amount of time to meet meaningful use requirements should far outweigh concern over potential payment adjustments. This is especially true given that hospitals already have a mechanism in place to settle payments once actual data are available—the Medicare cost report, which they routinely use. Therefore, NAPH recommends that all hospitals be allowed to demonstrate meaningful use through the end of FFY 2014 in order to avoid Medicare payment penalties in FFY 2015. For FFY 2015 and beyond, CMS should continue to allow hospitals to demonstrate meaningful use the year prior to the

[12] 2012 NAPH HIT Issue Brief and Survey of Members.

[13] Ashish K. Jha, M. F. Burke, C. DesRoches, M. S. Joshi, P. D. Kralovec, E. G. Campbell, and M. B. Buntin, "Progress Toward Meaningful Use: Hospitals' Adoption of Electronic Health Records," *The American Journal of Managed Care*, Volume 17 (12 Spec No.)**:** SP117-SP124 (Dec. 2011), http://www.ajmc.com/publications/issue/2011/2011-12-vol17-SP/Progress-Toward-Meaningful-Use-Hospitalsu2019-Adoption-of-Electronic-Health-Records

payment penalty year, with retroactive readjustment for hospitals that demonstrate meaningful use in the penalty year.

5. Meaningful use timelines should allow providers ample time at stage 1 to establish a solid foundation for quality improvement through the use of HIT.

CMS should give hospitals and EPs who first meet meaningful use requirements in 2012 or later 3 years at stage 1. While NAPH supports CMS' decision to delay stage 1 for hospitals and EPs that first successfully attested to meaningful use in 2011, NAPH also believes that this flexibility should exist for hospitals and EPs that first attest to meaningful use in later years. Otherwise, CMS will be punishing hospitals that are later adopters of HIT.

Because of their expansive outpatient clinic and hospital systems, many NAPH members find the EHR incentive program timelines very aggressive. For all NAPH members, the costs of implementing comprehensive HIT systems, including all capital and staffing costs, far outweigh combined Medicare and Medicaid incentive payments. Many NAPH members have struggled to find the resources for necessary infrastructure upgrades and HIT-employee recruitment and retention. Since they often do not have sufficient staff and other resources to simultaneously implement HIT and train staff across a multiple-hospital system, as previously mentioned, many NAPH members are taking a multistep approach to implementation, starting with one hospital, one inpatient unit, or a group of clinics and then gradually expanding throughout the whole system over 1 to 3 years. Most NAPH members will not meet meaningful use requirements until FFY 2012 or later because of these constraints. It is important that some flexibility be preserved so that safety net systems are not unfairly disadvantaged for being larger health systems with fewer resources.

In addition, with only 2 years at stage 1, hospitals and EPs that first attest to meaningful use in 2012, 2013, or 2014 would be faced with the dual challenges of meeting stage 2 requirements and avoiding the Medicare payment penalty in the same year. These providers would potentially be financially punished by both the proposed payment penalty and a lack of an incentive payment. Therefore, NAPH strongly recommends that all hospitals and EPs be given 3 years at stage 1, regardless of the year that they first meet meaningful use requirements.

6. CMS should not make clinical quality measure (CQM) requirements more aggressive until it has sufficient data on CQM reporting from all types of hospitals and determines that electronic reporting to CMS is a feasible option among most hospitals.

For stage 1, hospitals are required to report on CQMs. However, they currently report on these CQMs via attestation (i.e., reporting numerators and denominators for each CQM) rather than electronically reporting patient data from their EHR system. While the stage 1 final rule required electronic reporting of CQMs, CMS has delayed electronic CQM reporting for stage 1 because of CMS' inability to receive this data. Therefore, neither hospitals nor CMS has experience with electronic reporting of CQMs. As a result, it is premature to aggressively expand CQM

requirements for stage 2. NAPH makes specific recommendations about the proposed CQM provisions below.

a. CMS should add more flexibility in CQM reporting and include safety net hospitals in its electronic reporting pilot.

NAPH disagrees with CMS' proposal to require hospitals to report CQMs electronically by the beginning of FFY 2014. CMS should continue to allow attesting to CQMs as an alternative to electronic reporting in FFY 2014. NAPH appreciates that CMS has continued to allow hospitals to report CQMs through attestation during their first year of meeting stage 1 meaningful use requirements. However, we believe attestation should continue to be included as an option for all hospitals until it has been effectively demonstrated that electronic reporting of CQMs is a viable option for all types of hospitals. Allowing attestation as an option is essential to ensuring that no hospital gets left behind due to unanticipated implementation barriers specific to a certain type of hospital. At a minimum, this extension of the attestation alternative should include FFY 2014. To assume electronic reporting will be a feasible option in fewer than 18 months is overly optimistic.

Further, for CMS to finalize this requirement before all measures are fully electronically specified and field tested would be premature. In general, electronic measures have specific requirements about what type of information should be documented; they require more standardization than non-electronic measures.[14] Without detailed electronic specifications far enough in advance, many providers will struggle to report these measures. In addition, it is unwise to finalize any electronic measure until there is enough evidence of its validity in the field to justify its inclusion as a truly meaningful electronic measure.

NAPH recommends that CQMs be reported for a sample of patients across all payer types. NAPH members have expressed a strong preference for reporting CQMs via a sampling method across all payers (i.e., Medicare, Medicaid, etc.). This method, which is similar to what is required for the Inpatient Quality Reporting (IQR) program, would be the least burdensome approach for most safety net hospitals. With their already limited resources, safety net hospitals must find ways to implement HIT as efficiently as possible. Allowing sampling would help them save time and resources, which they can then use to implement their EHR systems.

Finally, CMS should include safety net hospitals in its electronic reporting pilot. NAPH is encouraged that CMS has expanded the Medicare EHR Incentive Program Pilot for an additional year. NAPH believes it is paramount that CMS ensure adequate participation in this pilot by all types of hospitals, including safety net hospitals, since CMS has stated in the proposed rule that this pilot will be the basis of a future alternative method of electronically reporting CQMs. The alternative method will be in addition to the currently defined electronic portal. It is imperative that the experiences of all types of providers, including safety net hospitals, inform the development of this alternative method.

[14] "Electronic Quality Measures (eMeasures)," National Quality Forum, http://www.qualityforum.org/Projects/e-g/eMeasures/Electronic_Quality_Measures.aspx

b. Instead of separating the CQMs from the core and menu sets of measures and making them a global requirement based on participation year, CMS should implement different levels of CQM requirements based on each stage of meaningful use.

NAPH disagrees with CMS' proposal to make CQM reporting a global requirement for all stages of meaningful use beginning in FFY 2013. CMS should continue to tie CQMs to the core and menu measures for each stage of meaningful use instead of tying them to the EHR incentive program participation year. Currently, hospitals are required to report on 15 CQMs, which make up 1 of the 14 hospital core measures that are required for stage 1. Beginning in FFY 2014, hospitals attesting to meaningful use, regardless of stage, will need to report on 24 CQMs from a menu of 49.

Collecting and reporting CQMs is challenging for many hospitals. Hospitals beginning EHR incentive program participation in later years should not be expected to meet the same, more comprehensive, expanded CQM-reporting requirements as hospitals that have had multiple years of program experience with the initial requirements. Many safety net hospitals that are in their second year of stage 1 meaningful use in FFY 2014 would have to meet the same CQM requirements as hospitals that are in their first year of stage 2. This process would put hospitals that are later in adopting HIT at a disadvantage in meeting meaningful use stage 1 by requiring them to meet more aggressive requirements than others are meeting for stage 2. This runs counter to the staged approach to meaningful use, which was the intent of the legislative statute. For these reasons, CMS should not separate CQMs from the meaningful use core and menu sets of measures.

c. Newly proposed CQMs should be limited to measures endorsed by the National Quality Forum's (NQF's) Measurement Application Partnership (MAP) and already in use at the national level.

CMS should not finalize any newly proposed CQMs that have not been endorsed by the NQF's MAP. CMS should also only include new measures that are currently in use at the national level. NAPH disagrees with expanding the number of CQMs the same year (FFY 2014) that electronic reporting would be required for the first time—and before electronic reporting has been demonstrated as feasible. Moreover, NAPH believes that it is not appropriate for CMS to finalize any newly proposed CQMs that have not been recommended by the NQF's MAP. The MAP is authorized by the Affordable Care Act to advise CMS on all measures for public reporting, and its recommendations should therefore be followed in full when finalizing any new CQMs.

Specifically, the MAP did *not* recommend the following eight measures (NQF #):

- AMI-1—Aspirin at arrival for acute myocardial infarction (AMI) (0132)
- AMI-3—Angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction—acute AMI patients (0137)
- AMI-5—beta blocker prescribed at discharge for AMI (0160)
- SCIP-INF-6—surgery patients with appropriate hair removal (0301)

- HF-1—heart failure detailed discharge instructions (0136)
- Exclusive breastfeeding at hospital discharge (0480)
- First temperature measured within 1 hour of admission to the neonatal intensive care unit (NICU) (0481)
- First NICU temperature <36 degrees Celsius (0482)

d. Hospitals should only have to report CQMs from five out of six domains.

NAPH disagrees with the proposal that beginning in FFY 2014, hospitals attesting to meaningful use, regardless of stage, would need to report on 24 CQMs from a menu of 49, including at least one CQM from each of the six care domains. Instead, hospitals should only be required to report CQMs from five of the six proposed care domains.

NAPH supports the quality improvement goals of all six proposed CQM domains, which are clinical process/effectiveness, patient safety, care coordination, efficient use of health care resources, patient and family engagement, and population and public health. However, three of the six domains currently do not have a sufficient number of CQMs to give hospitals enough options to be able to effectively choose a CQM that fits their patient populations from each of the six domains.

Specifically, the population and public health domain only has two total measures, both of which are newly proposed; the care coordination domain only has two total measures, one of which is newly proposed; and the efficient use of resources domain only has four measures, all of which are newly proposed. Hospitals may have limited experience collecting and reporting any newly proposed CQMs that were not included in the stage 1 requirements. Because of the scarcity of measures in several of these domains, including some newly proposed measures, CMS should give hospitals flexibility by allowing them to report CQMs for five out of six domains. As hospitals move to electronic reporting of CQMs, this flexibility will be essential to ensuring that hospitals are able to meet CQM requirements.

7. CMS should not change the overall denominator for stage 2 meaningful use measures.

NAPH disagrees with CMS' proposal to change its overall denominator for stage 2 meaningful use measures. Unlike stage 1, where the denominators for most measures included only patients whose records were maintained using certified EHR technology, the denominators for all measures in stage 2 would include all patients admitted to the hospital's inpatient or ED setting.

Until CMS has enough data from stage 1 to determine how successful different types of hospitals have been in meeting stage 1 requirements, it is premature to make the denominator effectively larger for most measures, which would make those measures more difficult to meet. This concept is supported by the Medicare Payment Advisory Commission's (MedPAC's) recent concern over

the small number of hospitals and EPs who have successfully attested to meaningful use of EHRs.[15]

Because of a lack of data on stage 1 attestations for all hospitals, CMS should not change the overall denominator for stage 2.

8. CMS should allow EPs appropriate flexibility when demonstrating eligibility for EHR incentive programs and meaningful use.

NAPH strongly encourages CMS to allow hospital-based providers who own and maintain their own EHR system to qualify as EPs. In general, NAPH supports any incentive program changes that allow more hospital-based providers to qualify as EPs and that make EP reporting more seamless.

In the proposed rule, CMS seeks comments on whether additional providers could qualify as EPs for the Medicare and Medicaid EHR Incentive Programs if the EP requirement were more flexible. Specifically, the requirement would allow hospital-based providers who spend at least 90 percent of their time in the inpatient setting or ED (point of service codes 21 or 23) and who own and maintain their own EHR system to qualify as EPs. Although not formally proposed, this change could potentially help numerous safety net hospital providers who currently cannot qualify as EPs for an EHR incentive program because they are considered hospital-based.

NAPH members support this policy, as they believe that at least some of their inpatient and ED providers would qualify for an EHR incentive program under this expanded definition. Providers that practice in the inpatient setting or ED often lack the needed capital resources to maintain and update EHR systems that they independently own and operate.

NAPH also supports CMS' proposal to allow group reporting of meaningful use measures for EPs in the Medicare EHR Incentive Program. This proposal would mean EPs do not have to report measures on an individual provider basis. Many large urban safety net providers, with hundreds of EPs and limited infrastructure to support individual reporting on an EP by EP basis, will struggle to meet meaningful use requirements without this newly proposed reporting flexibility. For this reason, CMS should finalize this proposal.

Finally, NAPH urges CMS to allow EPs that meet AIU requirements for the first year of the Medicaid EHR Incentive Program to be exempt from the Medicare payment penalty. To preserve the flexibility afforded to EPs, meeting Medicaid AIU requirements should be deemed as meeting meaningful use requirements for purposes of the Medicare payment penalty in 2015 and subsequent years. It would be unfair to punish EPs who choose to participate in the Medicaid EHR Incentive Program by subjecting them to the Medicare payment penalty. For this

[15] Zach Gaumer, M. Gilman, and J. Richardson, "Update on Medicare electronic health records incentive payment program," Medicare Payment Advisory Commission (MedPAC), April 5, 2012, Brief Presentation, http://www.medpac.gov/transcripts/EHR%20incentive%20program%20presentation_April%202012%20final_version%202.pdf

reason, CMS should exempt EPs who meet AIU requirements from the Medicare payment penalty.

9. CMS should not finalize any stage 2 core or menu measures that are too aggressive or lack flexibility for hospitals.

In general, NAPH recommends that core and menu measures for stage 2 should only become more aggressive when there is sufficient data available on implementation experiences for all types of hospitals. In the appendix that follows this section (Appendix A), NAPH provides specific core and menu measure recommendations.

Our measure-specific comments reflect our high-level concern that little data exists on current levels of meaningful use attestation beyond early adopters. Based on our survey results, most NAPH members will not attest to meaningful use until FFY 2012 or FFY 2013.[16] Until data is available for a wider set of providers, requirements for these measures should not be made much more difficult to meet.

In addition, to optimize safety net hospital participation in the EHR incentive programs, NAPH asks CMS to consider safety net–specific challenges when finalizing stage 2 meaningful use measures. These challenges include NAPH members' vulnerable patient populations and large system size combined with a lack of resources. These underlying factors, which are reflected in our measure-specific comments in Appendix A, create real, tangible challenges to meaningful use. Based on these underlying factors, NAPH recommends that CMS follow the general principles outlined below when finalizing stage 2 measures:

1. All newly proposed measures for stage 2 should become optional, menu measures.
2. Stage 1 menu measures should not become core measures for stage 2 until there is sufficient evidence that all types of hospitals have been able to meet these requirements for stage 1. If these measures become core measures, their thresholds should not increase for stage 2.
3. The thresholds for stage 1 core measures should not be increased for stage 2 until there is evidence that all types of providers have been able to meet current thresholds for stage 1.
4. Hospitals should be allowed to use a 90-day reporting period to demonstrate meaningful use in their first year of meeting stage 2 requirements.

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[16] 2012 NAPH HIT Issue Brief and Survey of Members.

NAPH appreciates the opportunity to submit these comments. If you have any questions, please contact Xiaoyi Huang or Kevin Van Dyke at (202) 585-0100.

Sincerely,

Bruce Siegel, MD, MPH
President and Chief Executive Officer

Appendix A: Detailed Comments for Proposed Stage 2 Meaningful Use Menu and Core Measures

Safety net hospitals serve vulnerable populations that often have low technological literacy and access. For this reason, NAPH makes the following recommendations regarding measures that involve electronic information exchange among providers and patients.

a. CMS should proceed with caution when finalizing stage 2 measures that require hospitals to provide patients the ability to view online, download, and transmit information about a hospital admission.

Specifically, CMS should eliminate the stage 2 measure requiring more than 10 percent of all patients who are discharged from the inpatient or ED setting to view, download, or transmit information about their hospital admission to a third party. NAPH members predominantly serve low-income, minority patients who are uninsured or covered by public programs. Many of them do not have access to electronic information outside of the hospital. While Internet service may be readily available in most urban areas, many families do not have a computer at home or cannot afford the monthly cost of broadband access. In fact, in many communities served by NAPH members, less than 40 percent of residents have broadband access at home.[17]

Because of these realities, a large majority of NAPH members do not believe they can meet the requirement CMS has proposed by FFY 2014. For example, one NAPH member that has been an early adopter of HIT and is far along in its personal health record (PHR) implementation found that even when 100 percent of its patients were given information about how to sign up for the PHR, only 40 percent signed up, and less than 10 percent of all patients logged in more than once. While this hospital is trying to improve PHR utilization by implementing mobile interfaces for patients in English and Spanish, requiring 10 percent of patients to actually download information is seen as an unrealistic short-term goal.

In order to ensure safety net hospitals are not unfairly disadvantaged for serving our most vulnerable patients, CMS should use caution when moving forward with measures regarding patient use of HIT. And in this case, CMS should focus on whether hospitals have systems that patients can use to view, download, and transmit information about a hospital admission. CMS should eliminate the view, download, and transmit measure for stage 2.

CMS should also lower the threshold for the measure that requires hospitals to make admission information electronically available to more than 50 percent of all patients who are discharged from the inpatient setting or ED. The information must be online within 36 hours of discharge. Instead, NAPH recommends a threshold of 30 percent and a longer time period before hospitals have to make the information available online. Since this is a

[17] Gerry Smith, "Without Internet, Urban Poor Fear Being Left Behind in Digital Age," March 1, 2012, *Huffington Post*, http://www.huffingtonpost.com/2012/03/01/internet-access-digital-age_n_1285423.html

newly proposed measure, very little data exists to shed light on an appropriate threshold. Without proper data, measures should be conservative to allow as many providers as possible to meet the requirement.

NAPH also recommends that CMS make this measure part of the menu, rather than core, set of measures for stage 2. Moving any new measure immediately to the core set of measures without sufficient data on the implementation experiences of a wide range of hospitals is premature. Providers need the flexibility of the menu set, which allows them to choose options from a larger set of measures, while CMS gathers more information about hospitals' experiences reporting on the measure. Because this is a new measure, it should start in the menu set.

b. <u>For stage 2, CMS should scale back measures related to the electronic exchange of summary of care documents.</u>

NAPH disagrees with CMS' proposal to require hospitals to electronically exchange summary of care documents using certified EHR systems with a recipient who has no organizational affiliation with the hospital and who is using a different EHR vendor. CMS would require this for 10 percent of transitioning patients and referrals. NAPH recommends that CMS eliminate this measure.

While we agree with CMS' goal—to encourage the broad exchange of electronic health information—it will not be successfully met through this measure. To achieve this end, as part of its certification requirements, ONC should guide certifiers to require vendor testing to ensure providers that the product they are purchasing can both send and receive patient information to and from providers using different vendor products. Holding vendors accountable in this manner would be a more appropriate way of achieving interoperability.

In addition, this requirement would create challenges for safety net providers. Many NAPH members offer comprehensive services within their own systems, leading to relatively low transfer and referral volumes. At some members, more than 99 percent of patients are transferred or referred within the health system. When they do need to transfer a patient, many NAPH hospitals struggle to find providers at nonaffiliated organizations who will accept their discharged patients, who are often uninsured or covered by Medicaid. For these reasons, NAPH members would likely struggle to meet the required threshold.

In addition, nursing homes and other post-acute facilities have much lower EHR adoption rates compared to hospitals and ambulatory clinics.[18] Many NAPH members often have challenges finding other providers in their communities that have the ability to exchange information with them. For example, in 2010, only one-quarter of NAPH hospitals are linked electronically to a post-acute provider through their EHR.[19] For these reasons, a large majority of NAPH members have indicated that they would not be able to meet this measure by 2014.

[18] Larry Wolf, J. Harvell, and A. Jha, "Hospitals Ineligible for Federal Meaningful-Use Incentives Have Dismally Low Rates of Adoption of Electronic Health Records," *Health Affairs*, Vol. 31: 3: 505-513 (March, 2012), http://content.healthaffairs.org/content/31/3/505.abstract
[19] Jane Hooker and K. Reid, "Reducing Readmissions in Safety Net Hospitals and Health Systems," November 2011, http://www.naph.org/Main-Menu-Category/Publications/Quality/Reducing-Readmissions-in-Safety-Net-Hospitals-and-Health-Systems.aspx?FT=.pdf

NAPH is also concerned that this measure could force providers to change existing referral and discharge patterns in order to work with providers at unaffiliated organizations that use a different EHR system. This situation could lead to the unraveling of highly integrated systems, which is contrary to the goal of providing more seamless care transitions to improve the quality of care delivery. It could have severe unintended consequences for patient access and continuity of care by destabilizing current patient-provider relationships within closed systems of care.

Further, this requirement could be particularly problematic for safety net hospitals located in areas where there is one dominant EHR vendor. In many large urban areas where safety net hospitals are located, one EHR vendor (e.g., EPIC) controls a large majority of the market share, which means most providers in these communities use the same EHR vendor product. It would be nearly impossible for hospitals in these communities to exchange patient data for 10 percent of patients with providers using a different EHR product.

For these reasons, CMS should eliminate the measure that requires electronic information exchange between providers at nonaffiliated organizations who use different EHR vendor products.

In addition, NAPH recommends a lower threshold in the proposal requiring hospitals to provide a summary of care document (in paper or electronic format) to the receiving provider in more than 65 percent of care transitions or referrals. CMS should lower the threshold to 10 percent and make this measure part of the menu, rather than core, set of measures. As proposed, this requirement effectively creates an all or nothing super measure because the proposed summary care document would include 14 separate required elements for each patient (e.g., problem lists, care team members). If a hospital fails to fully implement any of the numerous summary of care list requirements—the most problematic of which are discussed below—the hospital would not get credit for implementing all other list requirements.

The proposed summary of care list includes up-to-date problem lists, medication lists, and medication allergy lists. These criteria have been some of the most difficult stage 1 measures for safety net hospitals to meet because this information is much more difficult to capture and keep current in an urgent environment such as the ED. Patients who seek regular care in these environments often lack an existing relationship with a primary care provider or specialist who regularly monitors and keeps this type of information up to date. It is much easier to collect this information in the inpatient setting, where patients often stay for a much longer period of time than they do in the ED. Because of these challenges, only slightly more than half of NAPH members are currently ready to meet the stage 1 thresholds for these measures.[20]

This proposed super measure also includes several new measures that were recommended as separate measures for stage 2 by the ONC for HIT policy committee. Instead of being separate measures, CMS has proposed that these measures be included in this new super measure. These measures include recording care team members, care plan goals and instructions, and discharge instructions within the EHR. The ONC for HIT policy committee recommended 10 percent

[20] 2012 NAPH HIT Issue Brief and Survey of Members.

thresholds for each of these measures because they are new measures that few hospitals currently collect electronically. If these measures are included in this new super measure, the threshold for each of these individual measures would be 65 percent. It would be challenging for hospitals to meet a 65 percent threshold on measures on which they have little experience collecting information using EHRs. For these reasons, NAPH recommends a threshold of 10 percent.

In addition, as mentioned earlier, moving any new measure immediately to the core set of measures without sufficient data on the implementation experiences of a wide range of hospitals is premature. Providers need the flexibility of the menu set, which allows them to choose options from a larger set of measures, while CMS gathers more information about hospitals' experiences reporting on the measure. Because there are new measures within the super measure, it should start as part of the menu set.

c. Stage 2 requirements for computerized provider order entry (CPOE) for medications, laboratory, and radiology should be less aggressive.

NAPH disagrees with CMS' proposal that hospitals must use CPOE for more than 60 percent of their medication, laboratory, and radiology orders for their inpatient setting or ED. Instead, NAPH recommends that for stage 2, CMS keep CPOE thresholds at the stage 1 level of 30 percent. NAPH has general concerns that this measure moves forward too aggressively with CPOE for stage 2. Little data exists on CPOE implementation progress across all hospitals, especially for late adopters of HIT. While a recent analysis shows that more than two times as many NAPH members have implemented CPOE in 2011 than had in 2008, CPOE remains a challenge for many NAPH members.[21] The stage 1 measure has been especially challenging for safety net hospitals that have implemented HIT for the first time within the past few years. It has required complex workflow changes that often take years to implement.

For example, at some hospitals, nurses have historically entered medication orders. Physicians at these hospitals are spending many hours in documentation training. With staff and resources already stretched thin at safety net hospitals, the added training time is a challenge. In addition, physician and nurse workflow patterns have had to be completely redesigned so that CPOE happens at the appropriate time in workflow processes to ensure high-quality care while optimizing physician productivity. For these reasons, CMS should keep thresholds at 30 percent for this measure.

NAPH also recommends that the three CPOE measures remain separate for stage 2. CMS' proposal creates an all or nothing CPOE measure by combining the three types of CPOE—medications, laboratory, and radiology. Failure to fully implement one of these three CPOE functionalities would mean that the provider would not get credit for implementing the other two.

[21] December 2011 HIMSS/NAPH webinar, "Health IT: Moving Toward Meaningful Use."

In addition, fewer than half of NAPH members have implemented CPOE for laboratory and radiology.[22] So even those who can meet the challenging requirements for medications may not receive proper credit if CPOE for medications is bundled with the other two CPOE measures. Because of these challenges, CMS should keep these three CPOE measures separate for stage 2.

Finally, as separate measures, both CPOE for laboratory and radiology orders should become menu, rather than core, measures for stage 2. As mentioned earlier, moving any new measure immediately to the core set of measures without sufficient data on the implementation experiences of a wide range of hospitals is premature. Providers need the flexibility of the menu set, which allows them to choose options from a larger set of measures, while CMS gathers more information about hospitals' experiences reporting on the measure. For example, implementing CPOE for laboratory and radiology orders will require significant workflow changes similar to those outlined for medications above. Because these are new measures not included in stage 1, they should start as part of the menu set.

d. <u>The three measures regarding the electronic exchange of information with public health agencies and registries should not become core measures, or CMS should not require a successful test for stage 2 meaningful use.</u>

NAPH disagrees with CMS' proposal requiring successful ongoing electronic submission of surveillance, immunization, and lab results data from hospitals to public health agencies and registries. CMS specifies that an unsuccessful test submission would not count as meeting this new stage 2 measure. NAPH recommends keeping these three measures as optional for stage 2, or allowing unsuccessful tests to count toward meeting the measure— both of which are the case for stage 1. Overall, NAPH members have concerns about making these measures more difficult considering current barriers to successfully exchanging this data with public health agencies and registries.

Currently, few public health entities can electronically receive this data due to third-party interface issues. These issues occur when hospitals are prevented from submitting their data to a third party that can successfully translate it into data that can then be received by public health agencies. In addition, few of these third-party vendors that facilitate the transmission of this data to public health entities have certified products based on the ONC for HIT's requirements, which is a necessary step for a test exchange with a public health agency to count towards meeting this meaningful use measure.

Based on CMS data, 79 percent of hospitals that have attested to stage 1 meaningful use requirements to date have deferred the electronic surveillance menu measure. It is the most commonly deferred menu measure overall.[23] In addition, several NAPH members have been unable to successfully exchange electronic surveillance data because their states are not currently able to electronically receive this data.

[22] 2012 NAPH HIT Issue Brief and Survey of Members.
[23] Robert Anthony, "Stage 2 NPRM Overview," Office of the National Coordination for Health Information Technology (ONC) HIT Policy Committee, March 7, 2012, Brief Presentation, http://healthit.hhs.gov/

Immunization data exchange has also been a very problematic measure for NAPH members. For example, one NAPH member has been using the same interface engine for electronic exchange for more than 10 years. This member is following all of the required interface standards and satisfying all of its state's immunization registry requirements. Nevertheless, this hospital has been forced to buy another product because its vendor has decided not to certify its interface for meaningful use. Because there are no allowances made for legacy systems, this hospital, which has met four other stage 1 menu measures, has been forced to delay attesting for meaningful use by at least 1 year. Another NAPH member hospital that has been successfully exchanging lab data with its public health agency for several years is still waiting on its vendor to complete the interface certification process.

Currently, only one in five NAPH members has the capability to exchange all three types of information,[24] and roughly half of NAPH members believe that they will either be unable to submit a successful test by FFY 2014 or are unsure. For all of these reasons, if CMS requires a successful test for stage 2, the three measures should remain menu measures. Alternatively, if CMS decides to make them core measures, a successful test should not be required.

e. <u>The measure requiring hospitals to provide patient-specific education resources should remain an optional menu measure for stage 2.</u>

NAPH disagrees with CMS' proposal requiring hospitals to provide patient-specific education resources identified by the EHR to more than 10 percent of all patients admitted to the inpatient setting or ED. This measure should remain in the menu set for stage 2, as it is for stage 1. For stage 1, this measure also includes the phrase "if appropriate." This phrase allowed hospitals to make exclusions for situations where appropriate information was not available for certain patient populations. Whether the appropriate patient-specific education resources are available is largely dependent on the characteristics of the patient population that a provider sees and the EHR technology it uses. For example, more than 100 languages are spoken by patients at NAPH member hospitals.[25] Some NAPH members have indicated that they face challenges getting these patient-specific education resources through their EHR in languages other than English and Spanish.

In addition, a majority of NAPH members have concerns about whether patient-specific resources at the appropriate literacy levels and with the appropriate cultural competencies can be successfully identified through the use of certified EHR technology. Only 33 percent of NAPH members have the functionality needed to access this information within their EHR.[26] Of those who can access this information via their EHRs, most NAPH members claim that the information they can access is usually written at a sixth- or eighth-grade educational level. These resources are not appropriate for many of the patients seen by NAPH members who often read at a second- or third-grade level, or in some cases are illiterate.

[24] 2012 NAPH HIT Issue Brief and Survey of Members.
[25] NAPH Hospital Characteristics Survey, 2010.
[26] 2012 NAPH HIT Issue Brief and Survey of Members.

For these reasons, the patient-specific educational resources measure should remain a menu measure for stage 2.

f. CMS should not finalize the menu measure requiring hospitals to record patient family history for stage 2.

NAPH disagrees with CMS' proposal requiring hospitals to have a structured data entry for one or more first-degree relatives (such as parents or siblings) of 20 percent of patients admitted to the ED or inpatient setting. While NAPH members agree that it is important to collect patient family history at the point of care, the lack of standards and recommended structures currently available for this measure makes meeting this requirement a challenge. For these very reasons, the ONC for HIT policy committee recommended that this measure be delayed until stage 3.

Even with available standards, this measure would be especially challenging for safety net hospitals. The proposed patient family history measure would require patients to provide complicated health information about their relatives. NAPH members have patients with limited health literacy, who in many cases cannot provide accurate health histories for themselves. Obtaining medical history information for their relatives will be even more challenging for many of these patients. Therefore, this information may not be accurate enough to add significant clinical value.

For these reasons, CMS should not finalize the proposed stage 2 menu measure that requires hospitals to collect patient family information.

g. Medication reconciliation for transitions of care should remain a menu measure for stage 2.

NAPH disagrees with CMS' proposal that the measure requiring hospitals to perform medication reconciliations for more than 65 percent of patients transitioned to their inpatient setting or ED become a core measure. NAPH recommends that this remain an optional, menu measure for stage 2. For stage 1, this measure was part of the menu set of measures and was only required for 50 percent of admitted patients. And according to CMS data, this stage 1 menu measure is one of the most widely deferred stage 1 measures among early adopting hospitals.[27] This high rate of deferral does not justify the measure becoming a required, core measure for stage 2 and the threshold being raised.

NAPH members in particular have struggled to meet this menu measure for stage 1. Of all members, 25 percent believe they will not have this functionality implemented until FFY 2013 or later. Safety net providers see many low-income patients who often do not have continuity of care outside of the safety net, a transferable medical record, or a consistent private provider in the community. For these reasons, manual medication reconciliation for transitions of care has long been a challenge for many NAPH members.

[27] Robert Anthony, "Stage 2 NPRM Overview," Office of the National Coordination for Health Information Technology (ONC) HIT Policy Committee, March 7, 2012, Brief Presentation, http://healthit.hhs.gov/

While safety net hospitals are working hard to improve medication reconciliation, accurately reconciling medications electronically is an even greater challenge. For example, one NAPH member—who has been relatively successful as an early adopter of HIT—has struggled to get medication reconciliation for transitions of care above the 50 percent threshold. While it is making tremendous progress, this hospital believes that this measure is more challenging for providers who serve vulnerable patient populations.

Because of the clear challenges this measure has presented not only to safety net hospitals but to all types of hospitals in stage 1, it should remain an optional, menu measure for stage 2.