National Association of Public Hospitals and Health Systems

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

Re: HIT Policy Committee: Meaningful Use Workgroup Request for Comments Regarding Meaningful Use Stage 2

To Whom It May Concern:

The National Association of Public Hospitals and Health Systems ("NAPH") appreciates the opportunity to submit comments to the Health Information Technology ("HIT") Policy Committee on the preliminary set of recommendations for Stage 2 meaningful use ("MU") requirements.

NAPH represents approximately 140 metropolitan area safety net hospitals and health systems. These hospitals and health systems are critical sources of care for low-income and vulnerable patients in their communities—about half of all the care provided by NAPH members is for Medicaid and uninsured patients. Medicaid continues to be the most important source of revenue for public hospitals, accounting for 35 percent of NAPH members' total net revenues. As major providers of primary, preventive, specialty inpatient and outpatient care to Medicaid and uninsured patients, NAPH members have embraced the promise of HIT to improve quality, coordination, and efficiency of care for their patients. And for that, we appreciate the Committee's efforts in laying out a framework for moving our nation's health care delivery system to the next phase in which electronic health records (EHRs) and health information exchanges are the norm and not the exception. NAPH members are also deeply committed to improving population health, health outcomes, and health status. For these safety net health systems, which operate large ambulatory care networks and are often closely connected to public health agencies, HIT is not only a tool for improving quality of care, but also a tool for eliminating disparities by ensuring that all patients receive evidence-based care, regardless of who they are.

Given NAPH members' commitment to improving the quality of care for vulnerable patients with complex needs, many have implemented robust EHR systems in both the inpatient and outpatient settings of their health system. These EHR systems allow physicians that practice

within the health system to have access to patient records no matter where the patient encounter occurs within the health system, including community clinics that are not hospital based. Through these efforts, NAPH members have been able to efficiently utilize their limited resources to effectively manage the health of the most vulnerable patients in their communities. Now more than ever, at a time when NAPH members are facing the possibility of significant Medicaid cuts due to budget crises at the state and federal levels, HIT incentive payment funds are critical to support the investments NAPH members have already made—based in part on anticipated support from this program—and are continuing to make in HIT and related quality and efficiency improvements.

We urge the Committee to consider your proposed changes to the meaningful use definition for stage 2 in the context of the challenges facing providers in the current environment. **Significantly, the meaningful use definition should not be so strict that the HIT incentive payment funds will not be available to providers to support their ongoing investments in technology and help them to continue to improve their care.** Not only are public hospitals facing the prospect of severe cuts to critical resources, but there are increasing demands on those resources as hospitals seek to comply with and participate in the many programs under health reform, as well as numerous other IT-related initiatives (such as the transition to the new ICD-10 coding standard, revised HIPAA transaction standards, and existing quality reporting programs). The meaningful use standards should not be so strict as to result in incentive payments for only the fraction of hospitals that already have sufficient resources to meet them, thus widening the existing resource disparity between providers.

We also question the Committee's belief that there will be adequate provider feedback by spring 2011 to shape its stage 2 requirements recommendations, and urge the Committee to delay the process until sufficient feedback on stage 1 can be obtained from a representative group of providers, including predominantly Medicaid providers. The Committee suggests that by the spring of 2011 it can review feedback on these proposed stage 2 measures "in the context of the early feedback from providers on experience with stage 1 MU" and "[t]hat input will come through many vehicles," including Medicaid.

Although some Medicare providers may have experience with MU by spring 2011, many Medicare providers that will eventually qualify for incentive payments in the first year need not have met the meaningful use requirements by that point, given the 90 day reporting period for the first year of the program. Even fewer providers that rely heavily on Medicaid are likely to be able to provide substantial feedback by spring 2011. Many Medicaid HIT incentive programs will have only just started and many may not even be approved. According to the CMS website, only 11 states are ready to register providers for Medicaid incentive payments, and CMS does not expect the other state programs to begin until spring or summer 2011. In any case, Medicaid providers are not required to meet meaningful use requirements in order to qualify for the first year of payments; they must only show that they have adopted, implemented, or upgraded certified EHR.

As a result, the feedback the Committee will be able to receive as of spring 2011 from providers with experience meeting stage 1 MU will likely not be representative. In particular, it will fail to represent providers more focused on Medicaid and even those Medicare providers that do not

immediately meet stage 1 MU standards. The lack of representation of Medicaid providers is likely to be particularly pronounced for eligible professionals (EPs), who must choose between the Medicare and Medicaid incentive programs. Since EPs qualifying for Medicaid incentive payments will likely choose to receive higher payments through the Medicaid program, the pool of EPs with stage 1 experience will under-represent Medicaid EPs if Medicaid programs are not up and running by spring 2011. High-volume Medicaid hospitals and EPs may also rely on the payments from their first year of participating in the Medicaid program to help them achieve meaningful use and thus qualify for Medicare and Medicaid incentive payments in later years.

Thus, the Committee should wait until a representative group of stage 1 MU providers is available before proposing stage 2 standards, and should convey the importance of this issue to CMS. Without appropriate feedback from a representative group of stage 1 MU providers, including predominantly Medicaid providers, the Committee will not know how to adjust or improve the stage 1 standards, or what practical barriers to/complications with implementation exist across a variety of providers with varying patient populations. Such feedback is particularly important given the high stakes of being unable to meet the meaningful use criteria and Congress's intent that this funding reach providers in order to incentivize the use of EHRs.

If the Committee does not have flexibility in when it must issue its final recommendations, you should further limit changes prior to receiving more feedback, for example, by permitting providers to continue with stage 1 criteria on even more measures than currently proposed and by not adding new objectives. Furthermore, if the Committee will be soliciting feedback from meaningful users in the spring of 2011, you should also actively solicit feedback from hospitals and eligible professionals that may not yet have experience with actually meeting meaningful use requirements, but that are high volume Medicaid providers working towards those requirements.

Finally, the Committee should align its existing requirements and any new recommendations with other provider quality and reporting programs. The goal of improving quality of care should not be undermined by placing unnecessary burdens on providers to conform to multiple, and sometimes, inconsistent requirements. For example, the Government Accountability Office just issued a report finding that the HIT incentive payment program and Medicare electronic prescribing program require providers to adopt and use technology that can perform similar electronic prescribing–related activities, but have different criteria for those systems and separate reporting requirements.[1] While CMS must have a role in the alignment and integration of programs, the Committee should undertake such a review and revise its recommendations accordingly before issuing final meaningful use quality measures and objectives.

NAPH agrees with the principles set forth in the comments of the American Hospital Association ("AHA"). We also ask the Committee to consider the findings from the AHA's recent member survey regarding the reality of hospitals' ability to meet the meaningful use requirements, and to review your recommendations with the goal of setting achievable requirements that will support providers in making meaningful improvements as compared to the current system.

[1] GAO-11-159, Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology (February 2011), *available at* http://www.gao.gov/new.items/d11159.pdf.

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NAPH appreciates CMS' consideration of these comments. If you have any questions, please contact Xiaoyi Huang at (202) 585-0100.

Sincerely,

Bruce Siegel, MD, MPH
Chief Executive Officer