AMERICA'S ESSENTIAL HOSPITALS

June 15, 2015

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

Ref: CMS-3311-P: Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Modifications to Meaningful Use in 2015 through 2017

Dear Mr. Slavitt:

America's Essential Hospitals appreciates the opportunity to comment on the above-captioned proposed rule. We support the Centers for Medicare & Medicaid Services' (CMS') work to encourage use of electronic health records (EHRs) by eligible hospitals (EHs) and eligible professionals (EPs) through the Medicare and Medicaid EHR Incentive Programs (meaningful use program). EHRs should be used to help providers improve the care they deliver without creating system and infrastructure burdens.

However, meaningful use requirements so far have proved quite burdensome for providers—particularly essential hospitals with scarce resources and diverse patient populations. The great majority of essential hospitals have implemented EHRs in their integrated health systems and become meaningful users of this technology. But America's Essential Hospitals remains concerned that as stage 2 of the program enters its second year, some essential hospitals are still experiencing difficulty with the program's structure, both in terms of their infrastructure and their diverse patient populations. The majority of EPs and EHs who attested in 2014 were in stage 1, meaning they have not yet met the higher thresholds and more exacting requirements of stage 2 measures. **To give these providers much-needed flexibility, we believe CMS should, without delay, make necessary changes to stage 2 that will reduce the burden on providers**

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and allow time for providers to build the capacity to successfully meet stage 2 measures.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our more than 250 member hospitals provide a disproportionate share of the nation's uncompensated care and devote approximately half of their inpatient and outpatient care to Medicaid or uninsured patients. Nearly half of patients at essential hospitals are racial and ethnic minorities who rely on the culturally and linguistically competent care that only essential hospitals can provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital industry—an aggregate operating margin of -3.2 percent, compared with 5.7 percent for all hospitals nationwide.[1] Through their integrated health systems, members of America's Essential Hospitals offer the full range of primary through quaternary care, including trauma care, outpatient care in their ambulatory clinics, public health services, mental health services, substance abuse services, and wraparound services critical to vulnerable patients.

Essential hospitals' mission to serve all, regardless of socioeconomic circumstance, and their diverse patient mix pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing electronic patient information, including poverty, homelessness, language barriers, and low health literacy. In addition to these challenges, half of our members operate at a loss. Many hospitals have already begun to receive penalties for not participating in the meaningful use program and others are no longer receiving Medicare incentive payments, which will cease for all hospitals after 2016. These circumstances compound essential hospitals' challenges and call for much-needed accommodations to ensure they are not unfairly disadvantaged for serving vulnerable populations and can continue to provide vital services to their communities.

We urge CMS to be cognizant of these factors as it makes changes to stage 2 of the meaningful use program, and to consider the following comments.

1. CMS should immediately finalize the 90-day reporting period in 2015 to allow all providers to benefit from the flexibility and should continue to allow for a 90-day reporting period for first-time participants in 2017 onward.

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[1]Reid K, Roberson B, Landry, C, Laycox S, Linson M. *Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013.* America's Essential Hospitals. March 2015. http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf. Accessed June 15, 2015.

CMS should immediately finalize its proposal to give all providers a 90-day reporting period in 2015. In addition, CMS should maintain the 90-day reporting period for first-time participants after 2016.

CMS proposes a 90-day reporting period tied to the calendar year for all providers in 2015 (EPs and EHs), including returning providers, to give these providers time to adjust to the more stringent requirements of stage 2 and also to allow them to prepare for the changed objectives and measures included in the proposed rule. In 2016, all returning providers must use a full calendar year reporting period. Moreover, while first-time participants in 2015 and 2016 will have a 90-day reporting period, CMS notes that as proposed in the meaningful use stage 3 proposed rule, the reporting period will be a full calendar year for all providers, including first-time participants, beginning in 2017. The only exception to the full year reporting period would be for providers in their first year of the Medicaid EHR Incentive Program.

America's Essential Hospitals has previously called on the agency to allow a 90-day reporting period in 2015 to give providers crucial flexibility. A 90-day reporting period allows these providers more time to update their systems and train their staff on the program's new requirements. Last year, providers were unable to adopt the 2014 version of certified EHR technology (CEHRT) in time to meet the program's deadlines because of vendor delays in making this software available. Many providers who encountered difficulty in obtaining and installing the 2014 version of CEHRT are still working to ensure their transition to the new software is complete. Therefore, the 90-day reporting period will be critical for providers in 2015 as they complete the transition to the new version of CEHRT and adjust to new objectives and measures.

This shorter reporting period is also crucial for hospitals in their first year of the program, who need additional time to make necessary technological and workflow changes as they prepare to report on meaningful use objectives. A shorter reporting period gives providers the option to choose any consecutive 90-day period in the year and to report on new program requirements for this shorter period of time, instead of having to collect data and meet thresholds for a whole year. Therefore, we are encouraged that CMS is choosing to incorporate feedback from stakeholders, and we urge the agency to finalize the 90-day reporting period in 2015 immediately so providers may take advantage of this change. However, CMS should continue to offer this flexibility for first-time providers in future years of the program. **As such, CMS should finalize a 90-day reporting period for all providers in 2015 and also should continue the 90-day reporting period for first-time participants in future years of the program.**

2. CMS should finalize its proposal to lower the threshold for measure 2 of the patient electronic access objective.

CMS should finalize its proposal to lower the measure threshold for the stage 2 patient electronic access measure to require at least one patient to view, download, or transmit his or her health information.

CMS proposes to modify the second measure of the patient access objective for all hospitals in 2015 as follows:

- Measure 2: At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or [critical-access hospital (CAH)] (or his or her authorized representative) views, downloads, or transmits to a third party his or her information during the EHR reporting period.

CMS also proposes a similar modified measure for EPs. Measure 1 of the modified stage 2 objective is unchanged from the current stage 2 measure, while measure 2 is revised to reduce the threshold from 5 percent to one patient. Because not all providers are adequately prepared to meet this measure, CMS should finalize its lower threshold for this measure.

The majority of providers, because they were still in stage 1 in 2014, did not have experience reporting on measure 2, which is in stage 2 only. Because this measure is dependent on patient action and not solely on the actions of the provider, it is one of the most difficult measures for providers in stage 2. Providers should not be penalized for failing to meet thresholds when performance on a measure is outside of their control. This principle is especially important for providers who disproportionately treat vulnerable populations. Members of America's Essential Hospitals predominantly serve low-income, minority patients who are uninsured or covered by public programs. Many of these patients are homeless, and they seek care at homeless health care programs and benefit from respite programs at essential hospitals. In addition to homelessness, patients' ability to access the technology necessary to meet these measures is affected by a variety of other sociodemographic factors, including income, education, and primary language. These patients often do not have electronic access to their health 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 Internet access. These unique circumstances faced by patients of essential hospitals render these measures even more difficult to meet. **To allow providers to concentrate their resources on improving the provision of care and health outcomes, and to not penalize providers for measures dependent largely on patient action, CMS should finalize its proposal to lower the measure threshold.**

3. CMS should maintain the phased stage structure of the program and allow hospitals three years at each stage as a way to gain experience before transitioning to the next stage.

CMS should maintain the current stage structure of the program but allow providers to meet the requirements of a stage for three years before moving on to the next stage. The agency should not finalize its proposal to place all providers—including those providers that otherwise would be in stage 1—in a modified version of stage 2 in 2015.

CMS proposes to have a uniform set of nine modified stage 2 objectives to which all hospitals will report in 2015, 2016, and 2017, regardless of which stage the hospital attested to in 2014. EPs would be required to attest to 10 modified stage 2 objectives and associated measures. All of these objectives will be required, thus eliminating the distinction between core and menu objectives in the program. Under this proposal, providers that were scheduled to attest to stage 1 objectives and measures in 2015 will be able to claim exclusions or attest to alternate specifications of measures. But, these alternate exclusions and specifications would no longer be available in 2016. **We strongly oppose this rushed timeline that would force all providers into the same stage without consideration for their previous experience in the meaningful use program.**

This proposal does not give providers enough time and resources to become current on the program's latest requirements. The purpose of the phased stage structure is to allow providers to become familiar with the requirements of the program and gain experience with measures and objectives before having to meet higher thresholds and requirements in the next stage. Forcing providers to attest to measures with higher standards without allowing them to first gain experience with the measures at a lower threshold is setting them up for failure. A hospital that was an early adopter of CEHRT and has demonstrated meaningful use since 2011 may have the systems, staff, and processes in place to transition to stage 2, while a hospital that first attests in 2015 or later will not benefit from this same experience. CMS should allow these latecomers to the program to build their way up to stage 2, instead of forcing them to enter stage 2 without the requisite preparation. Expecting all providers to be prepared for stage 2 measures in 2015 is unrealistic and inconsistent with the history of the program.

If CMS finalizes its proposal to require all providers to attest to modified stage 2 objectives in 2015, **the agency should, at the very least, extend the availability of alternate exclusions and specifications for stage 2 measures beyond 2015 for providers who would otherwise be in stage 1.** In the rule, CMS proposes that, in 2015 only, providers that would otherwise be attesting to stage 1 may receive exclusions for any stage 2 measures not in stage 1. For measures that are in both stages 1 and 2, but with different requirements or lower thresholds in stage 1, stage 1 providers may attest to and meet the stage 1 version of the measure. While we emphasize the importance of maintaining the traditional phased stage structure of the program, if CMS chooses to finalize its proposal to require all providers to attest to the modified stage 2 objectives, it will be vital for the agency

to continue allowing these exclusions in coming years. By allowing providers to claim these exclusions, providers who would otherwise be in stage 1 can build up experience with the stage 1 equivalent measures before being required to report on more stringent stage 2 measures.

CMS should also extend the exclusion for the electronic prescribing measure beyond 2015 for those hospitals that would otherwise be in stage 1 or were not planning on choosing this menu measure in stage 2. This measure is a menu measure in stage 2 and is not in stage 1. CMS does provide an exclusion in 2015 for this measure. But beginning in 2016, it would be required for all hospitals. Because the vast majority of hospitals have no experience with this measure, either because they are in stage 1 or because they chose not to report on this menu measure in stage 2, requiring this measure would be burdensome for hospitals.

To account for providers on different timelines of EHR adoption, CMS should allow hospitals to attest for three years at a stage before moving to the next stage. At a minimum, CMS should allow stage 1 providers to claim alternate exclusions and specifications for measures.

4. CMS should allow those providers that are ready to submit their attestation data to do so as early as August 1, 2015.

CMS should allow providers to submit their attestation data as early as August 1, 2015, instead of waiting until January 1, 2016. Under current policy, hospitals report on a fiscal year (FY) schedule and must submit their attestation data no later than two months after the end of the FY, which in 2015 is November 30, 2015. To avoid a payment penalty in FY 2016, hospitals in their first year of the program have to attest by July 1, 2015, under current policy. However, because CMS is shifting hospitals to a calendar year schedule in 2015, hospitals may report on any 90-day period that falls between October 1, 2014, and December 31, 2015. CMS says that because it needs to make required changes to its attestation system, providers (EPs and EHs) cannot submit their attestation data before January 1, 2016. Therefore, the proposed attestation window for providers for calendar year 2015 is January 1, 2016, through February 29, 2016.

Delaying the start of the attestation window will delay incentive payments for those hospitals that would have otherwise received them earlier. For example, a hospital participating for the first time in the program that has already collected data for a 90-day reporting period and is ready to submit its attestation data will have to wait until after January 1 of next year to attest and receive an incentive payment. A delay in attestation will also result in premature penalties for hospitals who demonstrate meaningful use for the first time in 2015. CMS states that it will begin to impose the penalty on hospitals whose first year of meaningful use is 2015 until CMS receives attestation data from those hospitals (which will not be until January 1, 2016, under CMS' current proposal). Even if these hospitals have

collected all of the necessary data to report by attestation, they are unable to attest until after January 1, and would thus begin to have their payments reduced on October 1, 2015 (the beginning of FY 2016). While CMS will later reconcile and reprocess these claims to make these providers whole, the provider will still initially have its inpatient payments reduced by the meaningful use penalty amount due to the delay in the start date of the attestation period. These changes will affect hospital budget processes by resulting in a delay in incentive payments and early assessment of penalties. **To avoid this scenario, CMS should allow all providers to attest beginning August 1, 2015.**

5. CMS should expand the definition of hospital-based EP to include services provided in hospital outpatient settings.

CMS should amend the definition of hospital-based EP to include services provided in the outpatient setting, so as to not penalize EPs providing nearly all of their services there. CMS currently defines a hospital-based EP as "an EP who furnishes 90 percent or more of his or her covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or emergency room setting in the year preceding the payment year, or in the case of a payment adjustment year, in either of the 2 years before such payment adjustment year."[2] The inpatient and emergency department settings are identified by place of service (POS) codes 21 and 23 of the physician claims form, respectively. CMS is seeking stakeholder feedback on also including POS 22 for the hospital outpatient setting in the definition of hospital-based EPs.

Hospital-based EPs are not eligible for incentive payments but also do not receive meaningful use penalties. It is one thing for clinicians who practice predominantly in the hospital outpatient setting to be excluded from incentives, but it would be extremely unfair to subject these clinicians to penalties. However, the way the regulations are currently worded, these clinicians would be subject to penalties if they do not adopt EHR systems that meet meaningful use requirements. As the meaningful use program shifts from incentives to penalties, the scope of the definition of a hospital-based EP should be expanded to include clinicians who provide services in the outpatient setting. In many cases, it is not practical to expect these providers to meet the meaningful use requirements for EPs, because they practice in a hospital-based setting and do not have their own EHR system. Therefore, these providers should not be penalized for failing to participate merely as a result of the care setting in which they practice. **To this end, CMS should amend the definition of hospital-based EP to include services provided in the hospital outpatient setting (POS 22).**

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[2] 42 CFR § 495.4

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Shahid Zaman, Esq., policy analyst, at 202-585-0124.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO