THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

March 15, 2010

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
Comments submitted electronically to http://www.regulations.gov

Re: Electronic Health Record Incentive Program

Dear Ms. Frizzera:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations, I welcome the opportunity to submit comments regarding the proposed rule published on January 13, 2010 specifying the criteria that eligible professionals (EPs) and eligible hospitals must meet to qualify for Medicare and Medicaid incentives as meaningful users of certified electronic health record (EHR) technology.

CHA strongly supports efforts to transition our health care system to one which fully integrates interoperable EHR use. EHRs will benefit the patients and communities we serve through better clinical care, increased care coordination, and enhanced patient communication and education. Health care providers will also benefit from increased efficiency and effectiveness through EHR use. While CHA shares the goal of EHR implementation sought by CMS' proposed regulation, we are concerned about several aspects of the proposal. Congress intended The American Recovery and Reinvestment Act of 2009 (ARRA) to provide much needed financial support to encourage health care providers and professionals to adopt EHRs. The requirements of the regulation implementing ARRA should be ambitious but achievable, and maximize, not hinder the availability and impact of incentive payments.

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Meaningful Use Criteria

Under the proposed rule, hospitals would need to meet all of 23 separate meaningful use criteria as well as other requirements in order to qualify for Medicare or Medicaid EHR incentive payments. CHA believes that some of the proposed criteria and their related measures, such as those related to computerized provider order entry (CPOE) and medication reconciliation, will be especially difficult to meet in the near term. Thus, instead of the proposed "all-or-nothing" approach, we would urge CMS to provide more flexibility so

that hospitals could qualify for EHR incentive payments even if they initially met only a certain minimum proportion or percentage of applicable meaningful use criteria. In this regard, we believe that it would also be reasonable to provide lower qualifying thresholds for smaller hospitals, such as those with fewer than 100 beds. Moreover, when a CPOE-related criterion is incorporated, preferably in a later stage of the process, we would urge CMS to include in both the numerator and the denominator orders for patients for whom the place of service code is 23, Emergency Room, Hospital. This would recognize that CPOE, which requires complicated behavior changes by clinical staff, often now logically begins in the hospital emergency department and that hospitals should get credit for taking this first step. Whatever is done should definitely avoid rushing the CPOE-adoption process since we believe this would raise significant patient safety issues.

CHA also recommends that the timeline for full meaningful use be extended to 2017. We believe this additional time is needed for hospitals, physicians, EHR vendors and others to do the necessary work. Among other things, this extended timeline would minimize the potentially disruptive effect that EHR adoption, implementation and use could have on work flow and patient care, and would recognize that EHR certification will be a time-consuming process for EHR developers. We believe that rushing all the necessary steps would be ill-advised.

We are also concerned that some of the proposed criteria relate to administrative functionalities, such as electronic insurance eligibility checking and electronic claims submission, which many hospitals now accomplish outside of an EHR. Thus, we believe it is inappropriate for the proposed rule to imply that these functionalities require use of an EHR. Further, if these are strictly interpreted as meaningful use criteria, it would presumably imply that hospitals would now need to seek certification of their administrative systems or be denied access to EHR incentive payments. CHA would consider this a step backwards. Thus, we urge CMS to drop these functionalities from the list of EHR meaningful use criteria or otherwise allow hospitals to continue to meet such criteria through existing, administrative systems rather than solely through some certified EHR technology.

In addition, while CHA supports the goal of using EHR for quality measure reporting, we object to the proposed attestation approach for submitting quality information in the near term. Until CMS is fully prepared to receive such information from EHRs, hospitals should simply continue to submit quality data via the established Reporting of Hospital Quality Data for Annual Hospital Payment Update (RHQDAPU) mechanisms. In this regard, we suspect that it will take CMS several years to reach the point where it can efficiently receive quality data from EHRs and thus we suggest that data submission via EHRs be deferred until FY 2013 for hospitals without compromising their ability to qualify for EHR incentive payments prior to that time.

Finally, CHA is concerned that many of the proposed measures for meaningful use criteria would be difficult for hospitals to document and even require chart review or other manual processes, which would be rather ironic since the goal is to provide incentives for meaningfully using electronic health records. We urge CMS to re-examine the various measures with this in mind and to work with the Office of the National Coordinator (ONC) for Health Information Technology to be certain that certified EHR technology will be capable of generating the data and performing the calculations necessary for documenting meaningful EHR use. Furthermore, measure reporting under the EHR incentive program should be coordinated with the measures in the Medicare pay-for-reporting program. We recognize that this may require changes to a number of the proposed meaningful use measures.

Eligible Hospitals

CMS proposes to identify hospitals eligible for EHR incentive payments solely based on the CMS certification number (CCN) and to make Medicare and Medicaid EHR incentive payments on a per-CCN basis. However, this approach would mean that multiple hospitals currently identified by a single CCN would be significantly disadvantaged. In particular, if they qualify for incentive payments, the amounts they receive would be lower than those received by similarly situated hospitals having separate CCNs. This does not strike us as fair or reasonable. Thus, we urge CMS to identify alternative means for distinguishing between obviously separate hospitals (even if they have the same CCN) so that each facility may qualify for EHR incentive payments on its own merits and receive what any similarly situated hospital would receive by way of incentive payments.

Hospital-Based Eligible Professionals

ARRA stipulates that hospital-based eligible professionals are not eligible for Medicare payment incentives or penalties. CHA believes however that CMS has proposed an overly broad definition that would exclude from eligibly for incentive payments professionals providing care in an office or clinic located in a hospital-owned facility. The proposed definition appears to erroneously assume that such physicians would be using the inpatient EHR purchased by a hospital and/or using an ambulatory EHR at no cost to the health professionals in question. Denying access to EHR financial incentives to these physicians would be inconsistent with the goal of expanded EHR use and enhanced electronic communication between various participants in the health care delivery system. Thus, CHA urges CMS to re-examine this issue and to take advantage of whatever discretion it has to adopt a final definition of hospital-based professional that would minimize negative consequences.

Medicaid Incentive Program

CHA notes that the proposed rule would permit States to seek CMS approval to add additional meaningful use objectives. However, CMS makes clear that the Secretary "would not accept any State proposed alternative that does not further promote the use of EHRs and healthcare quality or that would require additional functionality beyond that of certified EHR technology." CMS also explicitly states 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 payment." All of this means that any additional State meaningful use requirements that the Secretary approved would apply to EPs electing to receive Medicaid EHR incentive payments or eligible hospitals that qualify only for Medicaid EHR incentive payments.

CHA finds it somewhat reassuring that the Secretary apparently plans to take a very conservative approach when considering State requests for additional meaningful use criteria. We also wholeheartedly endorse CMS' proposed "deeming" of hospitals qualifying for Medicare EHR incentive payments as also qualifying for Medicaid EHR incentives. However, given the obvious challenges that EPs and hospitals will face in demonstrating meaningful EHR use and meeting other relevant requirements, we believe it would be best if CMS announced in the final rule that State requests for additional meaningful use criteria would not be considered for the foreseeable future, say for at least the first five years of the EHR incentive program. In addition, we ask that CMS verify that the regulatory text explicitly incorporates the promised "deeming" policy.

Finally, in terms of eligibility for Medicaid EHR incentive payments, we believe that CMS should include critical access hospitals since such hospitals are, by definition, general, acute-care hospitals with an average length of patient stay of 25 days or fewer.

Regulatory Impact Analysis

CMS estimates that under the proposed rule, Medicare and Medicaid EHR incentive payments would total between $14 and $27 billion over 10 years, an amount far lower than the one originally estimated by the Congressional Budget Office at the time the American Recovery and Reinvestment Act (ARRA) was enacted. CHA is troubled by the CMS estimate and we believe that it provides additional evidence that the proposed criteria and measures for demonstrating meaningful EHR use and other proposed eligibility requirements are simply too tough and risk denying hospital and health professional access to funds that would assist them in enhancing their use of EHR technology. We do not believe that the Congress contemplated such a risk when it went to the trouble of

including EHR incentive payment provisions in a bill primarily intended to stimulate economic recovery. We, again, urge CMS to re-examine the issues addressed in the preceding comments and develop a more balanced final regulation.

We hope the preceding comments are helpful. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran at 202-721-6300.

Sincerely,

Michael Rodgers
Senior Vice President, Public Policy & Advocacy