HANYS Healthcare Association of New York State

Proud to serve New York State's Not-For-Profit Hospitals, Health Systems, and Continuing Care Providers

Daniel Sisto, President

March 12, 2010

Charlene Frizzerra
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-0033-P
7500 Social Security Blvd
Baltimore, MD 21244-1850

(Submitted electronically**)**

Ref: CMS-0033-P

Dear Ms. Frizzerra:

On behalf of New York's nearly 200 not-for-profit and public hospitals, the Healthcare Association of New York State (HANYS) and the HANYS Health Information Technology (HIT) Strategy Group appreciate the opportunity to comment on the Notice of Proposed Rule Making (NPRM) titled, *Medicare and Medicaid Programs; Electronic Health Record Incentive Program*, published by the Centers for Medicare and Medicaid Services (CMS) in the *Federal Register* on January 13, 2010 [CMS-0033-P].

HANYS' HIT Strategy Group is comprised of 40 hospital chief information officers representing hospitals across New York State.

New York's hospitals are a microcosm of hospitals throughout the United States. Among HANYS' members are the largest public hospital systems in the country, major teaching hospitals, community hospitals, and the smallest Critical Access Hospitals (CAHs).

New York hospitals are at varying stages of electronic health record (EHR) adoption. Very few are early adopters and among the nation's most advanced users of HIT. Many more are on the path to adoption, but have a long way to go before they will be able to achieve their HIT goals. Some of our members from throughout the state are just setting foot on the pathway to adoption.

All of these institutions share a common goal: to successfully adopt and implement use HIT tools, and enable their nurses, physicians, and other health care professionals to effectively these tools to achieve the delivery of high-quality care for patients.

HANYS has valued the opportunities HANYS and HANYS' HIT Strategy Group have been given to speak directly with CMS staff who developed the proposed approach to implementing the Medicare and Medicaid EHR incentive program as authorized by the American Recovery and Reinvestment Act (ARRA) of 2009.

We share your commitment to using HIT to improve health and health care, and commend CMS for promulgating the first regulation of its kind to establish EHR and quality measurement and reporting linked to Medicare and Medicaid payment policies. HANYS appreciates the inherent challenges of drafting such a regulation in a way that will truly allow for increased HIT adoption and consequential use among a broad and varied field of hospitals within the restrictive timeframe allowed by law.

HANYS' comments are based on our understanding of the intent of ARRA, the federal stimulus bill, to swiftly and directly incentivize the widespread and successful use of EHRs in the delivery of patient care, and within a legal framework that would allow for flexibility in the design of how providers meet the meaningful use standard. Further, HANYS' comments are rooted in an assessment of the current level of EHR adoption in New York hospitals and characteristics of the vendor marketplace.

HANYS and HANYS' HIT Strategy Group's concerns with the proposed rule are considerable:

- Should the rule be finalized without substantial improvements, we believe the vast majority of New York hospitals would fail the "all-or-nothing" test the proposed rule puts forward as the incentive program begins.
- We are concerned that many hospitals would be unable to meet the high bar the regulation alludes to in Stage 3 by 2015, and would thereby be subjected to deep Medicare payment cuts.
- We believe the narrow definition of hospitals eligible for the incentive program would leave multi-campus hospital systems that share a single Medicare provider number, and CAHs with a Medicaid volume above 10% financially disadvantaged.
- The proposed narrow definition of eligible professional would leave almost 30% of physicians ineligible for this stimulus program.

HANYS developed its comments under the guidance of HANYS' HIT Strategy Group, whose members have also provided robust and significant advice and counsel to the American Hospital Association (AHA) in its preparation of comments on CMS-0033-P. HANYS' HIT Strategy Group concurs with and supports the full comments submitted to CMS by AHA, including AHA's detailed recommendations for an alternative and flexible approach to defining and achieving the meaningful use criteria.

HANYS' comments include data and analysis derived from an HIT adoption survey of hospitals in New York in 2009 conducted by the University of Albany Center for Health Workforce Studies, a member of New York's Health Information Technology Evaluation Collaborative (HITEC). Data were obtained from 148 hospitals in the state, for a response rate of 75%.[1]

[1] McGinnis, S., Moore, J., and Kaushal, R. (Unpublished Draft) *Health Information Technology Adoption in New York Hospitals.* Rensselaer, NY: CHWS; 2010.

Our comments focus on the following issues pertaining to the Medicare and Medicaid EHR Incentive Program NPRM:

- providing flexibility in the framework of meaningful use;
- delaying automated reporting of quality measures to federal fiscal year (FFY) 2013, and other quality reporting recommendations;
- broadening the definitions of hospitals and physicians eligible for the Medicare and Medicaid EHR incentive program so that:
    - multi-campus hospitals sharing a single Medicare provider number are eligible as individual institutions;
    - CAHs with a Medicaid volume of 10% or more are eligible for the Medicaid incentive program; and
    - physicians delivering at least 10% of their services as ambulatory visits are considered eligible for the incentive program, even if that care takes place in a hospital-affiliated clinic or outpatient department;
- addressing technical payment issues to ensure maximum effectiveness of ARRA capital investment in EHR technology; and
- ensuring Medicaid HIT incentive program requirements mirror those for the Medicare program.

Flexibility Must Characterize the Framework of Meaningful Use

CMS' Proposal: CMS' proposed rule on the meaningful use of certified EHR technology would establish 23 specific electronic health record functionality, and 35 quality measurement reporting requirements that all eligible hospitals—regardless of size, location, or other characteristics—would need to meet fully to qualify as meaningful users to access the incentive payments. After the initial date of effectiveness of Stage 1 requirements—October 1, 2010—the later requirements, yet to be determined, would become more expansive over time with new Stages tied to quality improvement. All eligible providers would need to meet all Stage 3 requirements and performance standards by FFY 2015 to be considered a meaningful user and avoid the steep Medicare payment penalties established under the law.

Rationale for Change: We believe the approach of increasing requirements over time has merit, as do most of the specific requirements themselves. The proposed meaningful use framework would, however, set the all-or-nothing bar unreasonably high. The impractical approach fails to recognize the important work hospitals are doing now to use EHR systems to improve the quality of patient care. Currently, New York hospital EHRs with functionalities less numerous than, or different from, those spelled out in the proposed rule are yielding significant improvements in the delivery of patient care—improvements that are *meaningful* for patients.

As HANYS and HANYS' HIT Strategy Group commented to the National Coordinator for Health Information Technology, David Blumenthal, M.D., regarding the HIT Policy Committee's draft definition of meaningful use released last June:

> *"Meaningful use should not have to be achieved by following only one, linear pathway. Hospitals will come into the road of adopting EHR technology from many onramps. Allowing flexibility in the design of the varied phases of meaningful use would enable hospitals to best meet the needs of their patient populations and their institutional quality goals. To ensure quality improvement, there needs to be cohesiveness and harmony among the different EHR functionalities hospitals implement. Ultimately, it is for the patient that EHR adoption and use should be "meaningful."*[2]

Without a degree of flexibility in the framework for meaningful use, the all-or-nothing approach put forward in the CMS NPRM would have the unintended consequence of some hospitals forgoing the prospects of working toward the incentive payments because the resources necessary to do so in the tight timeframe are beyond their reach.

Consider the case of a five-hospital system in New York, on the verge of signing a contract with an HIT vendor to install inpatient EHR systems in all five of its facilities. Given the intense resources that both the vendor and the hospitals will need to direct to achieve meaningful use in time to draw down incentive payments, the decision has been made to forgo attempting to meet the all-or-nothing criteria at some of the system's hospitals. Were flexibility built into meaningful use that recognized progress in implementing systems short of the all-or-nothing approach, the system's strategic plan would likely call for all campuses to simultaneously work to achieve the incentive payments. Now the goal is to manage to avoid the steep payment penalties that will be imposed on each hospital individually if they are not meaningful users of a certified EHR by FFY 2015.

We strongly encourage CMS to allow for a degree of flexibility for hospitals in meeting the meaningful use criteria over time. Flexibility is necessary given:

- the generally gradual manner in which hospitals procure and adopt systems;
- the low rate of EHR adoption in hospitals;
- limits to vendor capabilities; and
- the tight timeframe prescribed by ARRA.

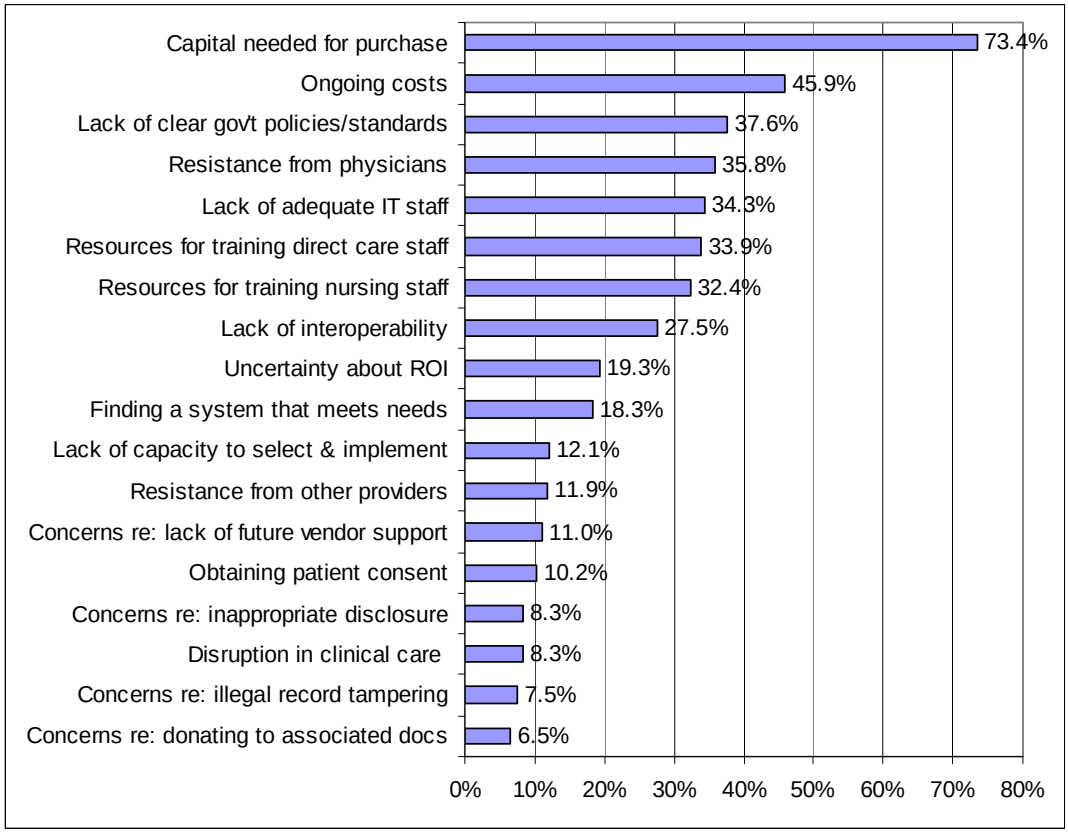
Hospital EHR Adoption Strategy Generally Requires Gradual System Installation

Flexibility in meeting the proposed requirements of meaningful use is necessary. CMS' rigid framework for achieving meaningful use, where all EHR functionality and quality reporting criteria must be met before a hospital could qualify for the incentive program, belies the reality of how New York hospitals procure, install, and use EHR systems. In general, hospitals in New York State tend to put in place EHR systems in a manner that is gradual, fitting the quality improvement goals of the institution within an environment of limited financial resources.

[2] HANYS and HANYS' HIT Strategy Group official comment letter on the HIT Policy Committee's first draft definition of "meaningful use" of certified EHR technology, submitted electronically, June 26, 2009, to David Blumenthal, M.D., National Coordinator for Health Information Technology

New York hospitals characterize lack of access to capital as the most significant barrier to broad EHR system procurement (see Figure 1). Historically, New York hospitals have suffered among the lowest bottom line margins of all hospitals in the United States. Based on HANYS' financial survey data, New York hospitals bottom line margins at the end of 2008 were *negative* 6.2%.

Figure 1. Percent of Hospitals Reporting Various Factors to be Major Barriers in Adopting Electronic Health Records[3]

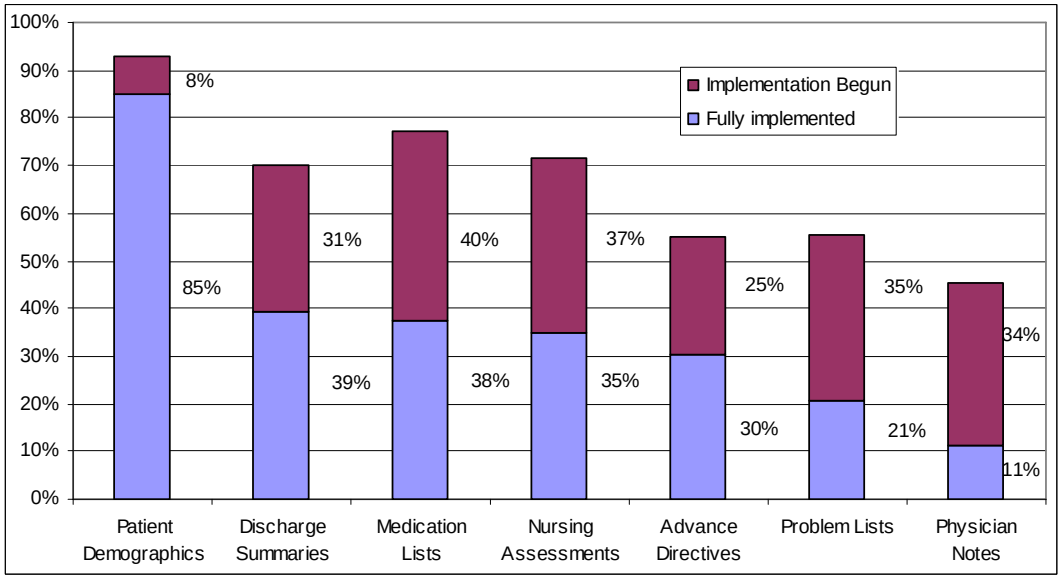


Given this lack of capital, New York hospitals' EHR adoption strategies often call for an incremental approach to purchasing and installing systems. The results of this gradual approach are evident in the most recent and comprehensive HIT adoption survey data available from New York hospitals.

Figure 2 shows the implementation status of an array of EHR functionalities related to meaningful use. Adoption levels are greatest for more basic functionalities, such as the collection of "patient demographics" whereas rates lag behind for functionalities that are more challenging to implement, like maintaining an up-to-date "problem list" of current and active diagnoses. These data point to the incremental nature of EHR adoption.

[3] McGinnis, S., Moore, J., and Kaushal, R. (Unpublished Draft) *Health Information Technology Adoption in New York Hospitals.* Rensselaer, NY: CHWS; 2010.

Figure 2. Implementation Status of Electronic Clinical Documentation Functions[4]



The Nascent State of EHR Adoption in New York Hospitals

Flexibility is needed in CMS' final rule establishing the meaningful use requirements for the practical reason that the distance from current level of EHR adoption in New York hospitals to meeting all proposed EHR functionality and quality measurement requirements is far too great to be considered reasonably achievable within the tight timeframe prescribed by ARRA. According to the University of Albany Center for Health Workforce Studies' 2009 survey of New York hospital HIT adoption,

> *"ARRA appears to be influencing initial adoption plans the most among the hospitals that were least likely to have an electronic system. Thirty percent of hospitals had no electronic systems other than patient demographics and/or results viewing functions. Forty-four percent of these hospitals reported plans to expedite initial HIT systems purchases . . . ."* (p. 28)

While ARRA may be influencing initial adoption, it is these hospitals that will struggle most to achieve meaningful use without adequate flexibility built into the definition that recognizes the incremental and gradual approach needed for effective EHR adoption.

EHR Vendors Need Time to Improve Products, Train Staff, Gear Up for Hospital Installations

Flexibility in meeting the proposed meaningful use requirements is also critical because the vendor marketplace is ill-prepared to meet the EHR functionality and quality reporting requirements put forward in the proposed rule. There is not a single vendor in the country whose

[4] McGinnis, S., Moore, J., and Kaushal, R. (Unpublished Draft) *Health Information Technology Adoption in New York Hospitals.* Rensselaer, NY: CHWS; 2010.

products are currently able to meet the EHR requirements set out in the proposal. Vendors and providers do not yet know which will be the certifying body for EHR systems or what will be the full certification process to be spelled out by the Office of the National Coordinator.

In addition to the technical challenges vendors face in upgrading their currently installed products and implementing new products capable of meeting the proposed requirements, vendors also face a shortage of well qualified health informatics staff. The shortage is broadly recognized.

ARRA authorized the establishment of programs geared toward training more informatics professionals. Under this authorization, the Office of the National Coordinator oversees the $120 million Health IT Workforce Program. That investment is critical, though it will not be enough to meet the burgeoning demands for more informatics professionals. In describing the Health IT Workforce Program, the U.S. Department of Health and Human Services indicates,

> *". . . estimates based on data from the Bureau of Labor Statistics (BLS), Department of Education, and independent studies indicate a shortfall over the next five years of approximately 51,000 qualified health IT workers required to meet the needs of hospitals and physicians as they move to adopt electronic health care systems."*[5]

In New York State, 34% of hospitals report a lack of adequate IT staff as a major barrier to EHR adoption (see Figure 1).

An academic medical center in New York has just begun the process of installing inpatient EHR systems developed by a well-regarded vendor. The hospital reports the vendor's informatics staff as being inexperienced. This may speak to the challenges vendors have in hiring informatics staff with a depth of knowledge and skill.

The technical and workforce shortage challenges facing vendors will impede hospitals' ability to meet the proposed meaningful use requirements.

The Short ARRA Timeline; Providers Will be Racing to Avoid Deep Medicare Cuts

Flexibility in meeting the proposed meaningful use requirements is also needed because the ARRA timeline imposed by which hospitals and physicians must be meaningful users to avoid steep Medicare payment reductions is excessively tight. Take, for example, the time it can take to achieve one of the most challenging EHR functionality requirements, implementation of computerized provider order entry (CPOE).

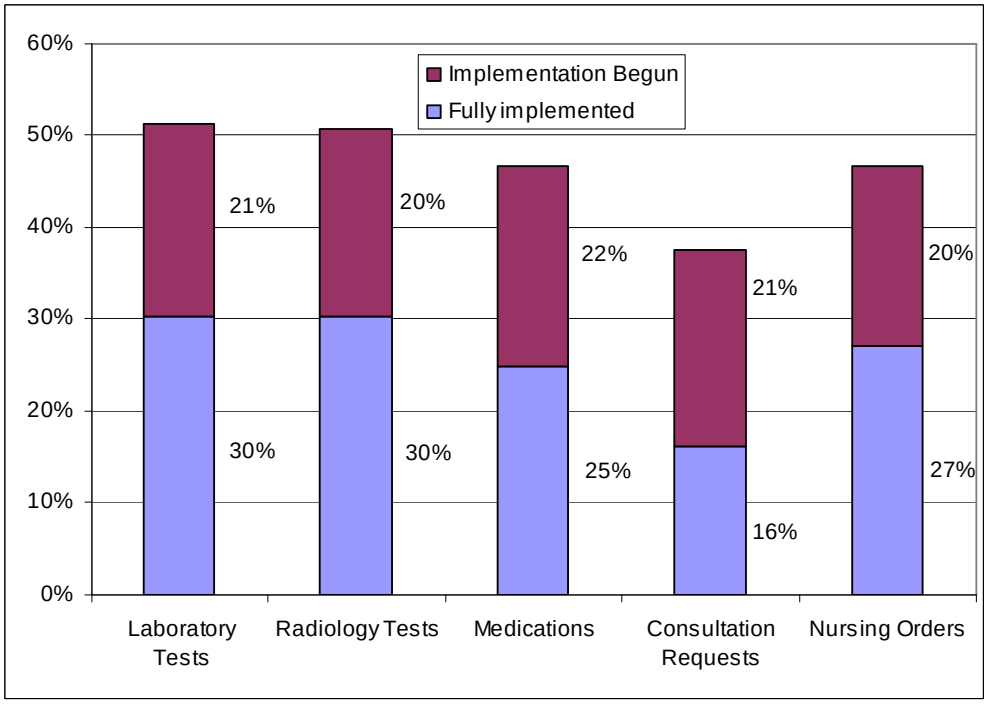
[5] U.S. Department of Health and Humans Services Web Site, *HITECH Priority Grants Program, Health IT Workforce Development Program, Facts at a Glance,* December 2009, http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_910058_0_0_18/Workforce_Fact%20Sheet_FINAL.pdf

A 2009 study by the independent market research firm KLAS Enterprises, LLC tracked the implementation experience of the health care customers of nine major vendors that had signed contracts to install core clinical systems in large hospitals (200 or more beds) in 2006 or 2007.

The KLAS study evaluated how many of those contracted installations were live with CPOE by the end of 2008. The vendor with the best implementation record had successfully gone live with CPOE at only 23% of its large hospital clients by the end of 2008 (an implementation window of between 12 to 36 months). Another had gone live in 21% of its large hospitals. At the other end of the spectrum, five of the nine vendors had not yet gone live with CPOE at any of their contracted hospitals.[6]

Figure 3 shows that roughly half of New York hospitals have either fully implemented or have just begun implementation of several critical CPOE functionalities. The other half of New York hospitals have not begun implementation of CPOE in these areas. Importantly, this functionality, implemented by only half of New York's hospitals, is just one of 23 complex functionalities hospitals will have to effectively adopt and implement under very tight timelines to meet the all-or-nothing approach proposed by CMS.

Figure 3. Implementation Status of CPOE Functions[7]



[6] *Meaningful Use Leading to Improved Outcomes*, May 2009, www.KLASresearch.com. ©2009 KLAS Enterprises, LLC.

[7] McGinnis, S., Moore, J., and Kaushal, R. (Unpublished Draft) *Health Information Technology Adoption in New York Hospitals.* Rensselaer, NY: CHWS; 2010.

One rural/small community hospital system in New York, fortunate enough to have recently finalized a contract with a reputable vendor to install ambulatory EHRs in the hospital system's outpatient departments and clinics, will begin what is projected to be at least an 18-month installation process. For providers yet to sign contracts, it is widely expected that installation timelines will increase as demand for already stretched vendor services increases.

Another large hospital system, an early adopter of EHR systems, is facing another dilemma. This system uses the same vendor for all of its inpatient and ambulatory systems. These legacy systems must be upgraded to meet the CMS proposed definition of meaningful use.

However, since the vendor installed the systems, it has dropped ambulatory systems from its product line and will not upgrade or certify the installed version. The hospital system is in negotiations with the vendor in attempts to reach an agreement where the vendor will upgrade the ambulatory system. No such deal has yet been reached. Changing vendors is beyond the financial reach of this system.

It is reasonable to expect that as demand for vendor products and services increase pursuant to the passage of ARRA, system installation time and challenges will likely grow.

We Endorse AHA's Alternative Approach to Defining and Achieving Meaningful Use

In consideration of ARRA's goal to stimulate the widespread adoption and meaningful use of EHRs and the impediments to achieving that goal inherent in CMS' proposed all-or-nothing, overly-rigorous approach, HANYS and HANYS' HIT Strategy Group wholly endorse and recommend AHA's alternative approach to defining and achieving meaningful use.

Our endorsement of AHA's alternative approach includes support for the specific recommendations AHA makes regarding modification of the proposed EHR functionality and quality measurement reporting requirements.

The AHA alternative limits the number of objectives that must be met in each successive period, building up to a system that meets 34 clinical care objectives by the time incentive payments are no longer available, which is 2017.

This alternative is built on a belief that, to be successful in achieving an e-enabled health care system that promotes good health and excellent health care, the EHR incentive programs must be:

- flexible enough to support organization-specific HIT implementation strategies that build on strategic quality improvement goals, capital investment planning, careful approaches to positive work process change, and staff and physician readiness;
- incremental, to follow the HIT adoption process;
- focused on objectives that promote improved patient safety and quality, according to evidence; and
- achievable, even by those who are furthest behind today.

Figure 4 (on page 12) illustrates the differences between the approach in the CMS proposed rule and AHA's alternative. The following sections describe the alternative in detail.

1. Establish the Full Scope of Meaningful Use Objectives Up Front

The final vision of EHR meaningful use should be specified now to provide hospitals the certainty needed to plan capital needs and implementation plans over the next several years.

As proposed, the requirements for Stage 1 leave out many key EHR functions to support safe, high-quality inpatient care, many of which are necessary precursors to more advanced clinical functions.

The full list of hospital meaningful use objectives should be built on the proposed rule (with some modifications) and expanded to include 12 additional objectives that have been discussed and proposed by the HIT Policy Committee for FFYs 2013 and 2015.

While the list of objectives required would remain relatively unchanged over the coming years, the scope of their use should accelerate, so that:

- levels of use increase over time (such as increased use of CPOE);
- use of structured data increases over time; and
- information exchange increases over time.

A final set of 34 recommended objectives, together with the changing requirements over time, are listed in the attached Appendix. The specific changes and additions to CMS' proposed list are provided in the next section.

Although specified in advance, the full set of hospital objectives should be reviewed periodically through rule-making. The regulatory requirements would represent the *minimum necessary* and certainly many hospitals would likely achieve a higher number of objectives and greater level of use to meet competitive pressures.

2. Lengthen the Timeframe for Achieving the Ultimate Vision for Meaningful Use

To support incremental adoption, the goal line for meeting full meaningful use should be extended to 2017 and encompass four phases of increased functionality and use (2011-2012, 2013-2014, 2015-2016, and 2017).

By law, 2017 is the first year in which no incentive payments are made. Under ARRA, providers that first become eligible for incentives in 2013 or later will receive payments through 2016. In addition, 2017 is the year when the penalties have been completely phased in. Although they start in 2015, the penalties increase in size through 2017. Therefore, the statute suggests 2017 as the year when providers should have finished their adoption process.

3. Take a Phased, Flexible Approach to Defining Meaningful Use

CMS should take a phased approach where hospitals can be considered meaningful users by meeting fewer requirements in the early years of the program, but building toward achieving the full set of meaningful use objectives over time. We recommend the following path:

- FFYs 2011-2012—Meet at least 25% of the objectives
- FFYs 2013-2014—Meet at least 50% of the objectives
- FFYs 2015-2016—Meet at least 75% of the objectives
- FFY 2017—Meet substantially all of the objectives

For small hospitals with fewer than 100 beds—one-fifth of New York State hospitals—that face special challenges in HIT adoption in addition to the omnipresent challenges hospitals throughout New York face accessing capital, we recommend that the share of objectives be lower in the first three stages:

- FFYs 2011-2012—Meet at least 15% of the objectives
- FFYs 2013-2014—Meet at least 30% of the objectives
- FFYs 2015-2016—Meet at least 60% of the objectives
- FFY 2017—Meet substantially all of the objectives

To be successful in achieving meaningful use, hospitals must have some choice and flexibility in the objectives they meet. Progress toward full implementation and meaningful use is, by its nature, specific to the staffing, strategy, and community of each institution.

Therefore, as HANYS and HANYS' HIT Strategy Group recommended to the HIT Policy Committee last year, we recommend to CMS that hospitals be allowed to choose the subset of the hospital meaningful use objectives they meet.

4. Establish a Meaningful Use Technical Expert Panel

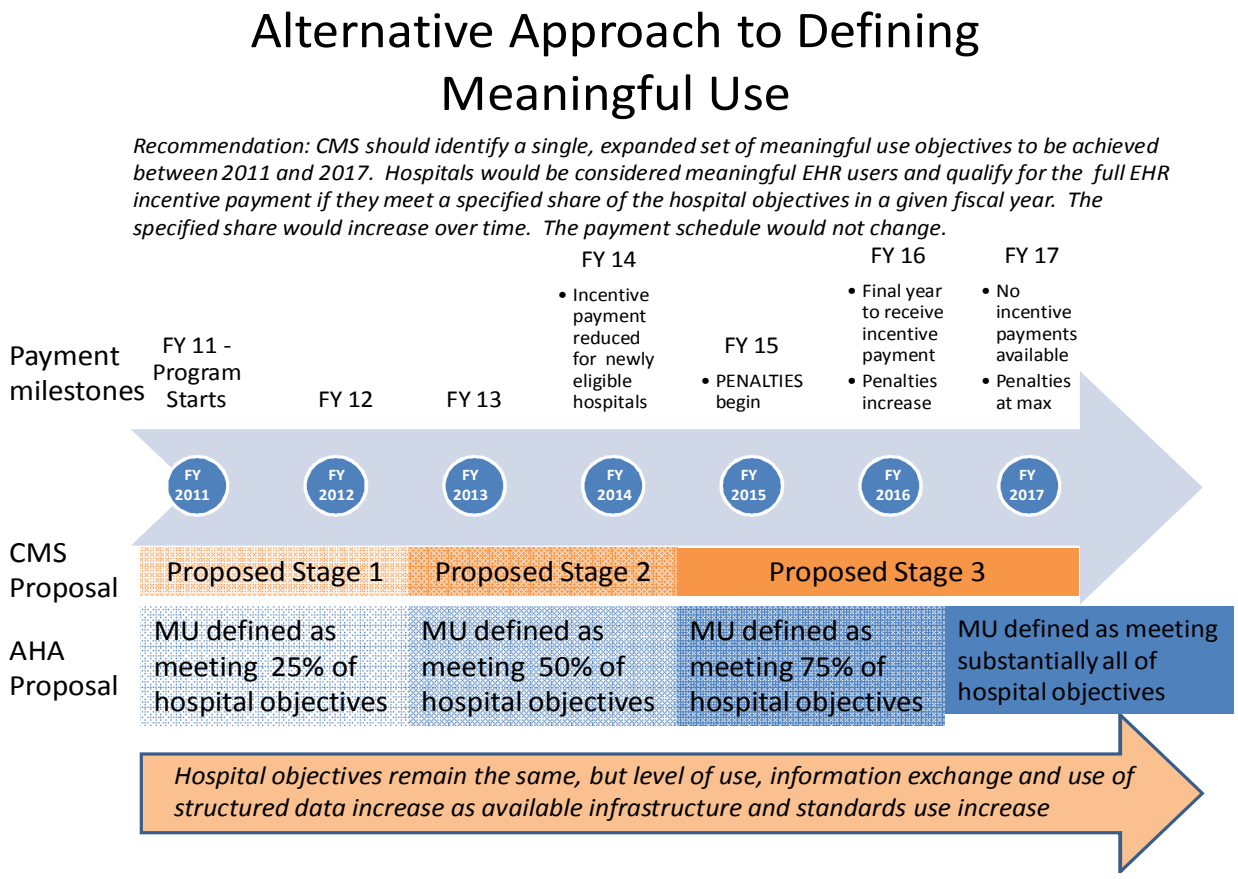
CMS should establish a Meaningful Use Technical Expert Panel with significant representation from hospitals and eligible professionals at various stages of implementation. The Meaningful Use Technical Expert Panel would provide input on the operational issues and feasibility of achieving meaningful use objectives over time, taking into account market conditions, advances in health information exchange, and the constraints facing subgroups of providers.

Our Recommendation: Flexibility Needed in the Meaningful Use Framework

We strongly urge CMS to adopt the AHA alternative approach. ARRA gives the Secretary of Health and Human Services (HHS) authority to define meaningful use. Therefore, CMS has the authority to adopt alternative timeframes and requirements that more closely match a realistic implementation timeline.

Without significant changes to the requirements and timeline, the goals established in ARRA and the flow of stimulus funds into the health care sector will not be fully realized.

Figure 4. AHA's Alternative Proposal



Delaying Automated Reporting of Quality Measures to FFY 2013 and Other Meaningful Use Quality Reporting Recommendations

Background: The foundation of every not-for-profit hospital and health care organization's mission is advancing the health of its patients and community by delivering high-quality health care. These devoted health care organizations and professionals work every day to implement new evidence-based practices, and assimilate new drugs, devices, and equipment to provide patients with the best care possible in an ever-changing medical environment. Many hospitals across New York State and the nation have sought to leverage the use of EHR systems to augment efforts to achieve hospital-specific care quality goals.

As part of these care quality goals, hospitals in New York State and across the nation are committed to voluntarily reporting quality data to government agencies and other entities. Most hospitals participate successfully in Medicare's pay-for-reporting program, the Medicare Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). Successful participation in this program allows hospitals to achieve their full Medicare payment update factor each year.

Participation in the RHQDAPU program requires hospitals in almost all cases to use a manual collection and reporting process, a significant administrative burden. Collection is manual because vendor systems are generally unable to extract such data from the EHR in a manner consistent with CMS requirements. Since its implementation in FFY 2005, the program has grown from a set of ten quality measures to 42 measures in FFY 2010.

After significant pressure from the hospital field and CMS' desire to collect quality data that is accurate, reliable, and grounded in best practices, CMS relies on quality measures developed and vetted by consensus-based entities—the National Quality Forum (NQF) and Hospital Quality Alliance (HQA)—for many measures used under the RHQDAPU program. Developing quality measures is a complex process that must take into consideration the latest evidence-based medicine and most effective way to capture processes and outcomes.

Using measures vetted by NQF and HQA is essential to ensuring the collection and use of accurate and reliable quality measures. Ill-chosen measures can have detrimental effects on the delivery of patient care as clinicians have been known to "practice to the measure." Doing so can result in less than optimal care being furnished to patients.

The collection of accurate and reliable quality measures is essential as Congress considers legislation as part of comprehensive health care reform that would implement a Medicare hospital value-based purchasing (VBP) program. Hospital quality performance under the VBP program under consideration would be measured using the predominantly NQF- and HQA-approved RHQDAPU data. We commend the congressional authors of this provision for the learned decision to gravitate toward requiring the use of consensus-based measures.

HANYS and HANYS' HIT Strategy Group believe it is critical that the implementation of any quality reporting requirements for hospitals, whether through VBP or EHRs, rely on fully vetted and consensus-based quality measures.

CMS' Proposal: To qualify as a meaningful user, CMS has proposed that hospitals must successfully submit 35 clinical quality measures to Medicare (or eight measures to Medicaid) through certified EHR technology. Importantly, the reporting of quality measures for the EHR incentive program are in addition to the reporting requirements under the current RHQDAPU program and other federal and state quality reporting programs. Only nine of the 35 quality measures proposed by CMS for the HIT meaningful use rule overlap with the measures currently used in the RHQDAPU program. Only 25 of the 35 measures have been adopted by HQA as appropriate for use by hospitals.

To fulfill the clinical quality reporting requirements of FFYs 2011 and 2012, CMS has proposed that providers use an attestation methodology to submit summarized data, generated using certified EHR technology, on the required clinical quality measures (including numerator, denominator, and exclusions).

CMS is expected to develop the capacity to receive EHR data electronically by FFY 2012. Beginning in FFY 2013, hospitals and eligible professionals would be required to submit patient-

level data via an EHR for calculation of quality measures. The proposed quality measures would also apply to the Medicaid incentive program, although CMS does provide some alternative Medicaid-specific measures for use by eligible hospitals.

Rationale for Change: As described above, there is near universal and voluntary hospital participation in the RHQDAPU program, where hospitals assume the administrative burden of manual collection and reporting of the necessary quality measures to CMS. The manual process is necessary, as vendor systems are generally unable to extract such data from the EHR in a manner consistent with CMS requirements.

Today, no EHR system in common use can generate the NPRM's set of proposed quality measures for the HIT incentive program. HANYS and HANYS' HIT Strategy Group concur with AHA that when EHR systems are able to achieve this functionality, hospitals' quality reporting burden will decrease and hospitals should then be able to generate an even broader array of quality information that can inform both hospital quality improvement efforts and the public.

However, much time-consuming work will need to be accomplished before the goal of electronic collection and submission of quality data is commonplace. Developing and testing measures for automated reporting will take considerable time to ensure that vendor products, once installed and in use, produce scientifically valid and reliable data.

For EHRs to be able to accurately collect and generate the information needed to create the proposed clinical quality measures, the measures need to be specified in a way that will enable electronic collection, the specifications need to be tested to ensure they result in an accurate and clinically reliable set of data, and EHR vendors need to be given the information and sufficient time to program those specifications into the data collection.

In addition, the collection of all the relevant information for the proposed quality measures requires significant and advanced EHR capabilities, including the ability to capture all relevant clinical documentation, from diagnoses to medication orders, to nurse and physician notes. As stated by AHA, the electronic capture of quality measurement information is really a capstone feature of an EHR, not one that should be in the starter set of activities.

It is essential for CMS to align its quality measurement-based programs so as to not increase the administrative burden on hospitals and to ensure commonality between quality measurement sets and programs. HANYS shares AHA's concern that the proposed rule takes a scattershot approach at picking and choosing from among existing measures, with no overarching quality improvement vision in mind. In fact, only nine of the 35 quality measures proposed by CMS for the HIT meaningful use rule overlap with the measures currently used in the RHQDAPU program. It is crucial that only measures chosen for use with the RHQDAPU program be considered for implementation in the HIT incentive program.

Further, lessons learned from the implementation of the RHQDAPU program and the potential transformation of that program from pay-for-reporting to pay-for-performance prove that a phased implementation, using only measures that have been adequately field tested and

thoroughly vetted by quality reporting stakeholders such as NQF and HQA can lead to the use of accurate and reliable quality measures that provide information that is useful to hospitals and the public, and advance patient care.

Lastly, CMS, in the proposed rule alludes to the use of quality measures collected through EHRs to evaluate performance and require eligible providers to meet certain performance thresholds to be considered a meaningful user of HIT in the later years of the program. HANYS is concerned that the collection of quality measures that differ from the RHQDAPU program and therefore that have not been fully vetted and tested, have the potential to harm providers in the later years of the program if CMS moves to evaluating hospital performance under meaningful use.

Our Recommendation: Delay Automated Reporting of Quality Measures to FFY 2013 and Other Meaningful Use Quality Reporting Recommendations

We strongly urge clinical quality measure reporting through EHRs be delayed until at least FFY 2013 so that the measures to be collected can be re-specified, tested, and implemented.

In addition, we endorse AHA's other recommendations relative to the clinical quality measures proposed for the HIT incentive program including:

- only measures chosen for use in the Medicare pay-for-reporting program should be considered for implementation in the EHR incentives program;
- measures should be selected for their potential to advance patient care and with the consultation of quality reporting stakeholders, namely NQF and HQA;
- measures selected for the EHR incentive programs should be comprehensively tested in the field to ensure that they are thoroughly specified, clinically valid when the data are collected through an EHR system, and feasible to collect; and
- measures should be phased in over time in clinically-related measure sets to allow for a smooth transition.

We also support AHA in urging CMS not to use any of the readmission measures. The readmission measures are explicitly inappropriate for reporting through EHRs and as required meaningful use criteria. Specifically, these 30-day risk-adjusted readmission rates for heart attack, heart failure, and pneumonia currently are calculated by CMS based on Medicare claims data. While hospitals could report on patients who are readmitted to their own facilities, hospitals currently have no way of capturing data on patients who were initially admitted to their facilities but later readmitted to another hospital.

In addition, hospitals do not have the data needed to apply the risk-adjustment methodology for the readmission measures that CMS uses. Finally, there is no evidence that use of EHRs has a direct impact on readmissions separate from the many other activities known to be effective.

Further, we, along with AHA, ask CMS to clarify in the final rule that reporting on the measures listed for the Medicare incentive program will be sufficient to fulfill Medicaid program requirements as well. The Medicaid measures should only be reported by hospitals for which the Medicare measures are not appropriate to their patient population.

Lastly, we and AHA understand that beginning in FFY 2012, CMS proposes that hospitals submit summary data on the clinical quality measures directly to CMS through one of several alternative transmission mechanisms. Given the sensitivity of the data and RHQDAPU program specifications, we believe CMS should never request that hospitals submit patient-level data to CMS, but that the data submitted should always be at the aggregated, summary level. We encourage CMS to state specifically that this is its intention in FFY 2012 and all future years of EHR incentive program reporting.

Broadening Eligibility for the HIT Incentive Program to Ensure Widespread Adoption and Use of EHR Systems by All Hospitals and Physicians

Allow Hospitals that Share Medicare Provider Numbers to Participate in the HIT Incentive Program

Background: ARRA defines hospitals eligible for the HIT incentive program as "subsection (d)" hospitals. Current law defines subsection (d) hospitals as general, acute care, short-term hospitals. ARRA's use of the term subsection (d) provides CMS with much flexibility as to how to identify hospitals eligible for the HIT incentive program.

CMS' Proposal: CMS has proposed to provide incentive payments to hospitals as distinguished by provider number on the cost report. Therefore, incentive payments for eligible hospitals would be calculated based on the provider number used for cost reporting purposes, which is the CMS certification number (CCN) of the main provider. For a system of hospitals that share a CCN, the payment incentives would be calculated using a single, not per-hospital, base amount, capping the per-discharge amount as if it were a single hospital's discharge total.

Rationale for Change: Use of the Medicare provider number will exclude many general, acute care, short-term hospitals—"subsection (d)" hospitals—that treat and discharge patients and require and use separate EHR systems, from participating in the HIT incentive program as separate institutions.

In New York State alone, a total of 46 hospitals are represented by only 20 Medicare provider numbers. CMS' proposal to use Medicare provider numbers to identify hospitals eligible for the HIT incentive program would preclude hospitals across New York State from the opportunity to receive more than $80 million in federal stimulus funding.

While there are advantages and efficiencies under the Medicare program for established networks of hospitals to group themselves under one Medicare provider number for various Medicare policies, these advantages are irrelevant to the implementation of this federal stimulus program. The exclusion of individual hospitals of multi-campus hospital systems from participation in the EHR incentive program is counter to the purpose of this ARRA-established stimulus program; to provide much-needed capital to providers to encourage the widespread adoption and use of HIT and the promotion of health information exchange.

The net effect of the narrow CMS proposal to define hospitals as based on CCN alone would result in ARRA incentives being distributed in a manner that does not foster widespread EHR adoption and use. Clearly, a health care system with multiple hospitals, but a single Medicare provider number, would be disadvantaged because the system would be eligible for only one base amount and would be much more likely to reach the discharge cap. In addition, such a health care system would be subject to EHR "incentive" program penalties at the system level, even if, for example, only one of the system's multiple hospitals was not found to be a meaningful user.

Further, we strongly agree with AHA's assessment that linking HIT incentive payments only to a single Medicare provider number would not accurately reflect the deployment costs of all EHR systems across all hospitals in a system that share one Medicare provider number. The total cost of EHR implementation far exceeds the purchase cost of the actual application or software. Even hospitals that are part of the same system often require significant variations in their EHRs, as local policies and processes must be incorporated in EHR utilization.

For example, installations must accommodate the differing network infrastructures of legacy software, physician preferences, clinical protocols, expert rules protocols, workflows, and ancillary system integration. In addition, a hospital system may encompass both a children's hospital and an adult acute-care hospital, each of which requires a different interface and clinical system. Further, hospitals incur additional administrative costs for necessities such as workstation installation, servers, staff training, and differences in clinical services among each of the hospitals, resulting in additional variation among facilities.

Finally, CMS specifies that states must establish an appeal mechanism through which Medicaid providers can appeal various state determinations and decisions, including whether a hospital qualifies for incentive payments. However, CMS does not establish the same appeal mechanism for Medicare providers to appeal qualification determinations. It is critical that CMS give providers the opportunity to review determinations and challenge those they believe are in error.

Our Recommendation: Ensure All Hospitals Are Eligible for the Incentive Program

We recommend CMS use an alternative to the Medicare provider number to identify hospitals eligible for the HIT incentive program that would appropriately allow the flow of federal stimulus funding in the form of separate HIT incentives to individual hospitals of multi-campus hospital systems.

This alternative, hospital-field consensus approach was presented by HANYS and members of HANYS' HIT Strategy Group to CMS in a meeting with CMS staff that developed the proposed rule.

Specifically, we join AHA in recommending CMS use a multi-pronged approach that allows a "hospital" to be defined in ways that acknowledge the varied organizational structure of multi-hospital systems, by:

- a distinct Medicare provider number;

- a distinct emergency department; or
- a distinct state hospital license.

In New York State, use of a distinct state hospital license known as the Permanent Facility Identifier (PFI) would ensure that all freestanding hospitals in New York that discharge patients would be eligible for the EHR incentive program.

HANYS recommends CMS modify and use the Medicare hospital cost report to collect the hospital-specific data necessary to calculate EHR incentives for individual hospitals of multi-campus hospital systems.

Allow Physicians to Appropriately Be Considered Eligible Professionals to Participate in the HIT Incentive Program

Background: ARRA contains a provision that excludes physicians defined as "hospital-based eligible professionals" from participating in the EHR incentive program. HANYS understands that the intent of this exclusion is to prevent hospitals from "double dipping" into the physician HIT incentive pool.

While subsets of physicians clearly provide inpatient hospital care only, using the hospital's inpatient EHR system, and should not be eligible for the HIT incentive program, CMS' strict interpretation of the law would preclude many physicians who provide the vast majority of all care they deliver in hospital outpatient department clinics. These physicians who provide primary and specialty ambulatory care would be ineligible to participate in the HIT incentive program under the CMS proposal.

However, CMS has much flexibility in determining what types of physicians can be eligible for the incentive program, given the language of the law. ARRA defines hospital-based eligible professionals as those who furnish substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified EHRs, of the hospital.

CMS' Proposal: Taking a strict approach to interpreting this provision, CMS has proposed to define hospital-based eligible professionals (for both Medicare and Medicaid purposes) as those who furnish at least 90% of their services in an inpatient hospital, outpatient hospital, or emergency department setting.

CMS considers as outpatient hospital settings all types of outpatient care settings in the main provider, on-campus and off-campus provider-based departments of the hospital, and entities having provider-based status. By CMS' own estimation, about 30% of the nation's doctors would not be eligible for the HIT incentive program, given the narrow definition of hospital-based eligible professional.

Rationale for Change: Hospitals in New York State and across the nation provide their communities with essential primary care services and other types of ambulatory care in hospital-owned clinics and ambulatory centers that can be located both on and off the campus of the main

hospital. In many communities, especially in under-served urban and rural areas, hospital-owned outpatient clinics are often the only source of primary and ambulatory care.

Based on CMS' proposal, many physicians providing care in hospital-owned clinics and ambulatory care centers will not be eligible to participate in the HIT incentive program. However, it is essential that physicians providing care in these settings be eligible to receive the EHR incentives to support hospital development of the EHRs in these hospital operated clinics.

Hospitals that provide these sources of primary and ambulatory care to their communities are primarily responsible for the adoption and implementation of EHRs in these settings. Ambulatory care EHRs are very different from inpatient EHRs because of the inherent differences in the types of care provided in these two settings. To wire these outpatient clinics and ambulatory centers, hospitals must make significant investments in technology beyond the investment needed to adopt and implement inpatient EHR systems. Not only is the additional system cost significant, but significant investment is needed to implement these systems, sometimes across multiple clinics and ambulatory centers, including costs to train physicians to use the ambulatory EHR, maintenance and upgrade costs, and to integrate the ambulatory EHR with the hospital's inpatient EHR.

Citing the inpatient focus of the EHR incentive program and the proposed meaningful use criteria, CMS notes in the NPRM that hospital investment in ambulatory EHRs is likely to lag behind investment in inpatient EHRs.

If implemented as proposed, CMS' regulation would preclude an important subset of physicians, those practicing in hospital-operated clinics and ambulatory centers, from participating in the EHR incentive program. This exclusion will only increase the lag in investment and adoption of ambulatory EHRs, creating a digital divide among and across provider settings. Exclusion of these physicians from participation in the EHR incentive program is counter to the purpose of this ARRA-established stimulus program: to provide much-needed capital to providers to encourage the widespread adoption and use of HIT and the promotion of health information exchange.

CMS' proposal to exclude many physicians providing care in hospital-owned clinics and ambulatory care centers from participating in the EHR incentive program is putting millions in new federal stimulus funding at risk. One hospital in upstate New York estimated that CMS' strict interpretation of physicians eligible for the program would preclude $3 million to $4 million in stimulus funds from flowing to the physicians practicing in its outpatient clinics.

Our Recommendation: Allow Physicians Who Primarily Deliver Care in Hospital Affiliated Outpatient Clinics to Be Eligible for the Incentive Program

We recommend CMS adhere to the intent of Congress as described in the Conference Report to ARRA, by allowing for ambulatory providers employed by hospitals or practicing within hospital-owned clinics and ambulatory centers to be classified as eligible providers for either the Medicare or Medicaid incentive program.

We endorse the AHA-recommended definition of a hospital-based eligible provider—physicians who would not be eligible to participate in the HIT incentive program. This approach would make eligible for the HIT incentives and provide much-needed stimulus funding to important subsets of physicians that provide essential primary care services and other types of ambulatory care in hospital-owned clinics and ambulatory centers.

AHA's recommendation builds on CMS' proposed policy for defining hospital-based eligible professionals by proposing additional steps to define these physicians that are, in part, based on other currently implemented CMS programs.

AHA's approach would define a hospital-based eligible professional as: a pathologist, anesthesiologist, emergency physician, hospitalist or intensivist for whom at least 90% of his/her billed claim lines have a site of service of the inpatient, outpatient or emergency department and for whom at least 90% of his/her claims do not contain an ambulatory-care visit code (as set forth in CMS' e-prescribing policy) and for whom the hospital funded more than 85% of the cost of the EHR.

In addition to the above recommendation, HANYS also endorses AHA's additional recommendations related to eligible professionals including the importance for CMS to:

- make hospital-based determinations and notify professionals of their status before the start of the payment year;
- give professionals the opportunity to review determinations and challenge those they believe are in error; and
- allow professionals the right to petition for a change in their hospital-based status when there is a material change in their organizational affiliation.

Allow CAHs to be Eligible for the Medicaid HIT Incentive Payments

Background: Under ARRA, all acute-care hospitals are clearly defined as eligible for the Medicare EHR incentive program, and CAHs are specifically named as eligible. ARRA explains only that Medicaid HIT incentive payments will be made available for qualifying hospitals that are acute care hospitals with at least 10% of its volume attributable to Medicaid patients and qualifying children's hospitals.

CMS' Proposal: CMS has proposed to define an acute-care hospital eligible for the Medicaid EHR incentive payments as a health care facility where the average length of patient stay is 25 days or fewer, and that has a Medicare CCN that has the last four digits in the series 0001 through 0879. CMS' interpretation of hospitals eligible for the Medicaid EHR incentive program excludes CAHs because all CAHs have a Medicare CCN with the last four digits in the series 1300 through 1399—a range of Medicare CCNs that would not be eligible for Medicaid incentives as proposed by CMS.

Rationale for Change: The clear intent of ARRA is to allow all hospitals the opportunity to qualify for both the Medicare and Medicaid HIT incentives to maximize the simulative effect of the incentive program. Although ARRA does not explicitly state that CAHs are eligible for the

Medicaid HIT incentive program, the use of the term "acute care hospital" clearly intends to capture hospitals with status as CAHs.

As described by AHA in its comments to CMS on this issue, under the Social Security Act, CAHs are, by definition, general, acute care hospitals with an average length of patient stay of 25 days or fewer. Section 1820(c)(2)(b)(ii) states that to be eligible to be a CAH, a hospital must make available 24-hour emergency care services—meaning it is a general hospital. Section 1820(c)(2)(b)(iii) states that to be eligible to be a CAH, a hospital must not have "more than 25 acute care inpatient beds . . . for providing inpatient care for a period that does not exceed . . . 96 hours per patient [emphasis added]." Thus, CAHs meet both the ARRA definition of being acute care hospitals, as well as CMS' proposed definition of being short-term general hospitals.

Because of the Medicaid volume threshold established by ARRA, HANYS estimates that four of its 13 CAHs would be eligible if CMS were to revise its definition of hospitals that can participate in the Medicaid HIT incentive program. AHA estimates that about 40% of CAHs nationwide would be able to meet the Medicaid patient volume threshold. The opportunity for these small hospitals with limited access to capital and limited IT resources and expertise to qualify for both the Medicare and Medicaid EHR incentives is essential to support EHR adoption and use in isolated rural areas.

Our Recommendation: Allow CAHs to Be Eligible for Both the Medicare and Medicaid Incentive Programs

Because CAHs by law are defined as acute care hospitals and meet CMS' proposed definition of being short-term general hospitals, HANYS supports AHA in recommending that CMS revise its definition of hospitals eligible for the Medicaid HIT incentive program to include CAHs by extending the proposed definition to include hospitals with a Medicare CCN that has the last four digits in the series 1300 through 1399.

Related to the definition of hospitals eligible for the Medicaid HIT incentive program, HANYS supports AHA's request for CMS to clarify that the 25-day length of stay limit is based on only inpatient, acute care days—other inpatient days, such as swing-bed days or those associated with skilled nursing, inpatient rehabilitation, psychiatric, or chemical dependency recovery stays, should not be included in the length of stay for these purposes.

We endorse AHA's recommendation for CMS and states to use Worksheet F-3, line 1, column 6 divided by Worksheet F-3, line 1, column 15 of the Medicare cost report to calculate the average length of stay for Medicaid incentive payment eligibility.

Technical Payment and Operational Issues

CMS' proposed rule to implement the Medicare and Medicaid HIT incentive program for hospitals includes many technical and operational payment issues. HANYS below offers recommendations on these technical issues for which HANYS either recommends CMS use an alternative approach or seeks clarification. If not addressed, these technical issues could cause

significant problems with implementation of the HIT incentive program and could slow access to HIT incentive payments for hospitals that are able to qualify as meaningful users.

Effect of the Medicaid HIT Incentive Payments on the Medicaid UPL Cap and Medicaid DSH Cap Limits

CMS' Proposal: The CMS proposal does not address the relationship of Medicaid HIT incentive payments to states' upper payment limit (UPL) calculations or to Medicaid Disproportionate Share Hospital (DSH) payment limits.

UPL rules require that states demonstrate they are not paying facilities more in total than Medicare would pay for the same services. While ARRA establishes a Medicaid HIT incentive payment methodology that is generally consistent with the Medicare payment methodology, it also provides states with flexibility to distribute the funds over a minimum of three years (rather than four years under the Medicare methodology), and to distribute up to 50% of the aggregate amount in a single year. States that choose to distribute the Medicaid incentive payments on the quickest allowable schedule would in fact be paying more than Medicare would pay during that year, potentially putting states at risk of exceeding the UPL cap under an overly strict interpretation of the regulations.

The hospital-specific Medicaid DSH cap limits each hospital's Medicaid DSH payments to the unreimbursed costs of care for Medicaid and uninsured patients. If Medicaid HIT incentive payments are included as Medicaid revenue in the calculation, it could cause hospitals to exceed their DSH cap, resulting in Medicaid DSH payment reductions that would offset the Medicaid HIT incentive payments.

Rationale for Change and Our Recommendation: Specific to the Medicaid UPL cap, we ask CMS to clarify that Medicaid HIT incentive payments will not be included in state UPL cap calculations. In reference to the hospital-specific Medicaid DSH cap, we ask that CMS specify that the Medicaid HIT incentive payments will not be included in the hospital-specific DSH cap calculation.

To avoid unintended consequences that could offset the value of Medicaid HIT incentive payments by causing reductions in other Medicaid funding mechanisms, we urge CMS to consider Medicaid incentives as separate and apart from other Medicaid program payments for patient care and specify that they will not be included in any calculation of total Medicaid payments for the purpose of determining Medicaid shortfalls, DSH payments, UPLs, or any general Medicaid program service.

Ensuring the Medicare HIT Incentives are Paid as Lump Sum Payments to Qualifying Hospitals

CMS' Proposal: CMS has proposed to require fiscal intermediaries (FIs)/Medicare Administrative Contractors (MACs) to distribute on an "interim basis" the Medicare HIT incentive payments to hospitals that have qualified as meaningful users of HIT.

Rationale for Change and Our Recommendation: We, along with AHA, urge CMS to clarify that the Medicare HIT incentive payments the FIs/MACs will distribute to qualifying meaningful users of HIT will be lump sum payments. Providing the Medicare HIT incentive payments in the form of a lump sum is especially important for hospitals and CAHs that are currently installing or upgrading systems to project the value of the HIT incentives and opportunities to obtain future lending.

Ensuring the Timeliness of the Medicare HIT Incentive Payments

CMS' Proposal: In the proposed rule, CMS does not set forth a timeframe in which a hospital or CAH can expect to receive the Medicare HIT incentive payments once the FI/MAC has all the supporting documentation that demonstrate a hospital is a meaningful user of HIT.

Under ARRA, eligible professionals that furnish services in a geographic health professional shortage area will receive a 10% bonus to their incentive payment. CMS has proposed to make the bonus payments to these eligible providers no later than two months after CMS has the necessary data.

Rationale for Change and Our Recommendation: We join AHA in asking CMS to be consistent by making incentive payments within the same timeframes as incentive bonus payments. We urge CMS to specify that the FIs/MACs must distribute the interim Medicare HIT incentive payments no later than two months after the hospital or CAH has demonstrated that they are a meaningful user of HIT. In addition, we urge CMS to specify that the FIs/MACs settle the final payment no later than two months after the hospital or CAH submits its cost report from the FFY that ends during the HIT incentive payment year (see "Cost Report Period" recommendation below).

Cost Report Period

CMS' Proposal: CMS has proposed to estimate a hospital's Medicare HIT incentive discharge-related amount based on cost report data using a hospital's discharges from the hospital fiscal year (FY) that ends during the FY prior to the HIT incentive payment year. A hospital's final Medicare HIT incentive discharge-related amount would be determined and settled based on its cost report from the FY that ends during the HIT incentive payment year.

Rationale for Change and Our Recommendation: CMS' proposal could potentially subject hospitals to a delay in distribution of incentive payments. Therefore, we join AHA in urging CMS to estimate a hospital's discharge-related amount based on its most recently filed cost report, and not based on the cost report that ends during the FY prior to the payment year.

Calculation of the Charity Care Ratio to Adjust the Medicare Share

CMS' Proposal: ARRA provides for an adjustment to the HIT incentive payment calculation to exclude charges related to charity care in determining the denominator of the Medicare and Medicaid share fraction. This adjustment has the effect of increasing a qualifying hospital's or CAH's incentive payments. To implement this provision, CMS has proposed to use data to be

submitted on the revised and yet-to-be-released cost report worksheet on Hospital Uncompensated Care (Worksheet S-10).

Section 112 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 directs the HHS Secretary to require hospitals to submit data on uncompensated care, including charity care, as part of the Medicare cost report. As a result, CMS recently proposed changes to Worksheet S-10 as part of the SCHIP requirements to the Medicare cost report.

CMS anticipates the revised cost report will be effective for cost reporting periods beginning on or after February 1, 2010. If a hospital's cost report does not contain the data necessary for CMS to determine its charity care charges, the charges will be deemed to equal zero.

Rationale for Change and Our Recommendation: HANYS is concerned that hospitals with cost reporting periods beginning on January 1, 2010 will not have the opportunity to report charity care data for the first year of the HIT incentive program. Specifically, New York State cost reports ending in FFY 2011 (October 1, 2010 through September 30, 2011), which CMS proposes to use to determine the final discharge-related amount for FFY 2011 incentive payments, would run from January 1, 2010 through December 31, 2010.

However, CMS anticipates that the revised cost report that captures charity care data will not be effective until cost reporting periods beginning on or after February 1, 2010. Therefore, a majority of New York State hospitals, which have a cost report period beginning on January 1, 2010, will be unable to report charity care data for FFY 2011 incentive payments if they are able to qualify as meaningful users in the first year of the HIT incentive program. This unfairly penalizes New York State hospitals because if they do not report charity care data CMS has proposed to deem their charity care charges to be zero.

We, with AHA, urge CMS to issue an interim final rule containing changes to the cost report stemming from its proposed rule last year, as well as newly proposed changes related to HIT. In this rule, CMS should accept further comment on proposed changes to Worksheet S-10 so that hospitals and other stakeholders will have the opportunity to weigh in on these changes in the context of HIT incentive payments.

However, we strongly urge CMS to make changes to Worksheet S-10 retroactive to cost reports beginning on or after October 1, 2009 to remedy the timing of the HIT incentive payments and reporting of charity care charges.

State Flexibility for Calculation of the Medicaid Patient Volume Threshold

CMS' Proposal: Under ARRA, Medicaid HIT incentives are available to qualifying hospitals that are acute care hospitals with at least 10% of volume attributable to Medicaid patients. To determine hospital eligibility for the Medicaid HIT incentives, CMS has proposed the Medicaid patient volume threshold be calculated using total Medicaid "encounters" for any representative 90-day period in the preceding calendar year as a percentage of total encounters for the same

period. CMS further proposed to allow individual states some discretion in determining the appropriate timeframe and data source for this calculation.

Rationale for Change and Our Recommendation: We join AHA in thanking CMS for allowing the states flexibility for calculation of the hospital 10% Medicaid patient volume threshold and we urge CMS to provide states with the maximum flexibility allowed to determine the Medicaid patient volume threshold.

Reconciliation of Medicare HIT Incentive Payments for CAHs

CMS' Proposal: Under ARRA, CAH Medicare HIT incentive payments will equal the Medicare share of their reasonable costs incurred for the purchase of certified EHR technology. CAHs will be paid through an interim payment subject to reconciliation. CMS in the proposed rule stated that the FIs/MACs will review CAHs' current and subsequent cost reports to ensure incentive payments are made appropriately. However, CMS did not provide any details on how it will modify the cost report to allow CAHs to report EHR costs.

Rationale for Change and Our Recommendation: We support AHA's recommendation urging CMS to promptly issue an interim final rule on the Medicare cost report that would include proposed changes to allow CAHs to appropriately report and capture EHR costs for the purposes of the Medicare HIT incentive payments. These changes must be effective for cost reporting periods beginning on or after October 1, 2010, as this is when CAHs are first eligible to receive incentive payments. The actual cost report forms containing these changes must be finalized in advance of October 1, 2010 to allow CAHs to plan appropriately.

Medicare Appeals Process

CMS' Proposal: CMS is proposing that state agencies develop an appeal process in which Medicaid providers will have the ability to appeal various state determinations and decisions in regards to EHR incentive payments. No similar appeal process has been proposed for the Medicare HIT incentive program.

Rationale for Change and Our Recommendation: We join AHA in urging CMS to implement a Medicare appeal process similar to its proposal of the state Medicaid appeals process under 495.370 (an appeal process for a Medicaid provider receiving electronic health record incentive payments).

Retention Period

CMS' Proposal: CMS has proposed that qualifying hospitals must maintain evidence of qualification of the HIT incentive payments for ten years after the date they register for the incentive program.

Rationale for Change and Our Recommendation: We join AHA in urging CMS modify the retention period for evidence of qualification to receive incentive payments to five years, which is consistent with other retention requirements.

Medicaid HIT Incentive Program

New York State has made significant investments in HIT in recent years. These efforts have been geared toward building a statewide HIT infrastructure, the State Health Information Network for New York (SHIN-NY) and as such, have focused almost exclusively on information exchange. To date, providing access to capital for hospitals to procure EHR systems has not been a state priority. We are encouraged by the prospects of the ARRA Medicaid HIT Incentive Program making available up-front capital to hospitals across New York, as financial barriers remain the most significant encumbrance to hospitals achieving EHR system procurement and installation.

HANYS and HANYS' HIT Strategy Group are working with the New York State Department of Health Office of Health Information Technology Transformation (OHITT) and the Office for Health Insurance Programs (OHIP), as these offices develop the state's plans for the Medicaid HIT Incentive Program and additional health information exchange (HIE) capacities.

OHITT and OHIP are preparing applications to the Office of the National Coordinator for HIT and CMS, respectively, in accordance with ARRA requirements. HANYS and HANYS' HIT Strategy Group have been invited to provide input to OHITT and OHIP as each prepares its application.

We are recommending to OHITT and OHIP the same priorities we have included below in these comments to CMS. We urge CMS to require a framework for the Medicaid HIT Incentive Program that will:

- provide the maximum allowable Medicaid incentive payment up front; and
- require **no** additional meaningful use requirements beyond what CMS determines, and accept the federal determination of a hospital's attestation of meaningful use as sufficient for Medicaid meaningful use determination.

Require States to Provide the Maximum Allowable Medicaid Incentive Payment Up Front

Background: ARRA allows state payout of the Medicaid HIT incentive payments to hospitals at 50% of the hospital-specific Medicaid HIT incentive aggregate amount in one year and up to 90% of the aggregate amount over a two-year period. Additionally, first-year Medicaid HIT incentives can be made to hospitals that show progress toward the adoption of an EHR, but are not yet meaningful users.

CMS' Proposal: As required by ARRA, CMS' proposed rule allows states the flexibility to push HIT federal stimulus funding to hospitals early in the program, but does not require states to do so.

Rationale for Change: As described earlier in this letter, hospitals across the nation and in New York State continue to characterize the most significant barrier to broad EHR system procurement as lack of access to capital. The University of Albany Center for Health Workforce

Studies 2009 New York hospital HIT adoption survey results indicate that 73% of New York hospitals consider access to capital to be a major barrier to EHR adoption (see Figure 1).

This adoption barrier has been exacerbated by the economic recession, tightening of capital markets, and continuing deteriorating hospitals' financials in New York State.

ARRA's flexibility to allow states to push Medicaid HIT funding to hospitals early in the program will assist hospitals in obtaining the much-needed capital to invest in the adoption of EHRs and provide a greater opportunity for hospitals to achieve meaningful use under both the Medicare and Medicaid HIT incentive programs.

While OHIP has indicated a desire to implement the Medicaid HIT incentive program in a way that would allow eligible providers to access as much of the incentives up front as possible, we recommend that CMS require states to implement the program in this manner.

Our Recommendation: Require States to Provide the Maximum Allowable Medicaid Incentive Payment Up Front

We join AHA in urging CMS to require states to pay hospitals the maximum incentive payments possible in their first two payment years—that is, 50% of the hospital's aggregate incentive payment in the first year and another 40% in the second year.

Require NO Additional Meaningful Use Requirements Beyond What CMS Determines

Background: ARRA gives states flexibility to establish additional criteria for eligible providers to qualify for Medicaid HIT incentive payments above what will be required to achieve the Medicare HIT incentives. The statute does indicate that the Secretary should make an effort to avoid duplicative requirements.

CMS' Proposal: CMS has proposed to create a definition of meaningful use for the Medicare HIT incentive program that would also serve as the minimum standard for the Medicaid program. As per ARRA, CMS has further proposed to allow states to add additional objectives to CMS' definition of meaningful use for Medicare or modify existing objectives only if those changes "further promote the use of EHRs and healthcare quality" and do not "require additional functionality beyond that of certified EHR technology."

Examples of additional criteria in the proposed rule include requiring providers to participate in health information exchange and requiring that providers link to immunization, lead screening, or newborn screening registries. CMS notes that, to be approved, these information exchange mechanisms must be readily available to providers and not represent a financial burden.

Rationale for Change: We join AHA in commending CMS for its efforts to ensure consistency in the EHR incentive program across Medicare and Medicaid. The requirements under the proposed rule are complex and will be extremely challenging for hospitals to meet, particularly under the suggested timelines. In addition, both CMS and the states will establish new application, reporting, and payment processes, which hospitals will need to master quickly to

demonstrate meaningful use. The potential for states to layer on additional meaningful use requirements would significantly complicate matters for all hospitals, and particularly for hospitals that serve patients in multiple states.

Also, as described above, New York State has made significant investments in HIT. These investments, however, have focused on developing a statewide infrastructure to support health information exchange, not on supporting hospitals and other providers for the procurement of HIT systems. Therefore, while the State of New York can be considered more IT-sophisticated than most, the adoption rate remains low, as borne out by the results of the University of Albany Center for Health Workforce Studies 2009 New York hospital HIT adoption survey.

Allowing states to add additional criteria to what will be required of hospitals to achieve the Medicare HIT incentives could prevent hospital access to much-needed capital to invest in the adoption of EHRs and would be counter to the purpose of this ARRA-established stimulus program. Further, allowing states to add additional criteria would create disharmony between the Medicare and Medicaid meaningful use requirements that will further complicate a complex program and could prove disadvantageously confusing for providers.

Our Recommendation: Require NO Additional Meaningful Use Requirements Beyond What CMS Determines and Accept the Federal Determination of a Hospital's Attestation of Meaningful Use as Sufficient for Medicaid Meaningful Use Determinations

We join AHA in urging CMS to implement a common definition of meaningful use for the Medicare and Medicaid HIT incentive programs and NOT approve any additional state criteria.

In addition to the above recommendation, HANYS and HANYS' HIT Strategy Group also endorse AHA's additional recommendation for CMS to "deem" hospitals that are meaningful users under Medicare as meaningful users under Medicaid, with no obligation to meet any additional or different, state-specific meaningful use requirements approved by the Secretary. CMS in the proposed rule preamble clearly proposes a "deeming" approach, the specific regulatory language at 495.312, with reference to 495.4, is less clear. CMS should add specific language on deeming to the regulatory language at 495.4, 495.8, or 495.310, or another appropriate place in the regulation text.

Conclusion

HANYS' member hospitals throughout New York State are encouraged by the prospect of achieving meaningful use status and thereby benefitting from the rewards of Medicare and Medicaid EHR incentive payments. The lack of access to capital, endemic in New York State, particularly during this time of economic recession, is the heaviest encumbrance hospitals bear to achieving greater levels of HIT adoption.

We are optimistic that CMS' final meaningful use regulation will reflect the comments offered by HANYS, HANYS' HIT Strategy Group, and AHA, allowing the success of the ARRA Medicare and Medicaid EHR Incentive Program with funding flowing to all hospitals and

physicians making a good faith effort to adopt and use EHR systems to improve the quality of patient care, better inform and engage patients, and achieve national health and health care goals.

Thank you for the opportunity to share our comments and recommendations.

Sincerely,

Daniel Sisto
President

DS:kk
Enclosure

Appendix

This attachment includes a graphic depiction of the alternative approach recommended in my comment letter and a complete list of the recommended hospital meaningful use objectives for 2011 to 2017, including recommended increases in the level of use, use of structured data, and health information exchange over time.

2011-2012 **Meet 25% (8) of:** **< 100 beds Meet 15% (5) of:**	**2013-2014** **Meet 50% (17) of:** **< 100 beds Meet 30% (10) of:**	**2015-2016** **Meet 75% (26) of:** **< 100 beds Meet 60% (20) of:**	**2017** **Meet substantially all of:**
1. CPOE (10% or more) 2. Drug-drug/drug-allergy checks 3. Drug-formulary checks 4. Structured problem list 5. Structured medication list 6. Structured medication allergy list 7. Record demographics 8. Record vital signs 9. Record smoking status 10. Incorporate structured clinical-lab data (50%) 11. Patient lists by condition 12. 5 clinical decision support rules 13. Electronic copy of health information to patients on request 14. Electronic copy of discharge instructions and procedures at discharge, upon request 15. Exchange key clinical information 16. Summary care record 17. Immunization registries (capability)	1. CPOE (10% or more) 2. Drug-drug/drug-allergy checks 3. Drug-formulary checks 4. Structured problem list 5. Structured medication list 6. Structured medication allergy list 7. Record demographics 8. Record vital signs 9. Record smoking status 10. Incorporate structured clinical-lab data (50%) 11. Patient lists by condition 12. 5 clinical decision support rules 13. Electronic copy of health information to patients on request 14. Electronic copy of discharge instructions and procedures at discharge, upon request 15. Exchange key clinical information 16. Summary care record 17. Immunization registries (capability)	1. CPOE (50% or more) 2. Drug-drug/drug-allergy checks 3. Drug-formulary checks 4. Structured problem list 5. Structured medication list 6. Structured medication allergy list 7. Record demographics 8. Record vital signs 9. Record smoking status 10. Incorporate structured clinical-lab data (75%) 11. Patient lists by condition 12. 25 clinical decision support rules 13. Electronic copy of health information to patients on request 14. Electronic copy of discharge instructions and procedures at discharge, upon request 15. Exchange key clinical information (CCD)	1. CPOE (substantially all) 2. Drug-drug/drug-allergy checks 3. Drug-formulary checks 4. Structured problem list 5. Structured medication list 6. Structured medication allergy list 7. Record demographics 8. Record vital signs 9. Record smoking status 10. Incorporate structured clinical-lab data (subst. all) 11. Patient lists by condition 12. 25 clinical decision support rules 13. Electronic copy of health information to patients on request 14. Electronic copy of discharge instructions and procedures at

2011-2012 Meet 25% (8) of: < 100 beds Meet 15% (5) of:	2013-2014 Meet 50% (17) of: < 100 beds Meet 30% (10) of:	2015-2016 Meet 75% (26) of: < 100 beds Meet 60% (20) of:	2017 Meet substantially all of:
18. Reportable lab results (capability) 19. Syndromic surveillance data (capability) 20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary *21. Use of evidence-based order sets (1 department)* *22. Electronic medication administration record (eMAR) (1 department)* *23. Bedside medication administration support (barcode/RFID) (1 department)* *24. Record nursing assessment in EHR (1 department)* *25. Record nursing plan of care in EHR (1 department)* *26. Record physician assessment in EHR (1 department)* *27. Record physician notes in EHR (1 department)* *28. Multimedia/Imaging integration (e.g., X-Ray viewing)* *29. Generate permissible discharge prescriptions electronically*	18. Reportable lab results (capability) 19. Syndromic surveillance data (capability) 20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary *21. Use of evidence-based order sets (3 departments)* *22. Electronic medication administration record (eMAR) (3 departments)* *23. Bedside medication administration support (barcode/RFID) (3 departments)* *24. Record nursing assessment in EHR (3 departments)* *25. Record nursing plan of care in EHR (3 departments)* *26. Record physician assessment in EHR (3 departments)* *27. Record physician notes in EHR (3 departments)* *28. Multimedia/imaging integration (e.g., X-Ray viewing)* *29. Generate permissible discharge prescriptions*	16. Summary care record 17. Immunization registries (submit data if possible) 18. Reportable lab results (submit data if possible) 19. Syndromic surveillance data (submit data if possible) 20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary *21. Use of evidence-based order sets (5 departments)* *22. Electronic medication administration record (eMAR) (5 departments)* *23. Bedside medication administration support (barcode/RFID) (5 departments)* *24. Record nursing assessment in EHR (5 departments)* *25. Record nursing plan of care in EHR (5 departments)* *26. Record physician assessment in EHR (5 departments)* *27. Record physician notes in EHR (5 departments)* *28. Multimedia/imaging integration (e.g., X-*	discharge, upon request 15. Exchange key clinical information (CCD) 16. Summary care record 17. Immunization registries (submit data if possible) 18. Reportable lab results (submit data if possible) 19. Syndromic surveillance data (submit data if possible) 20. Conduct or review a security risk analysis as required by HIPAA and implement security updates as necessary *21. Use of evidence-based order sets (substantially all departments)* *22. Electronic medication administration record (eMAR) (substantially all departments)* *23. Bedside medication administration support (barcode/RFID) (substantially all departments)* *24. Record nursing assessment in EHR (substantially all departments)* *25. Record nursing plan*

2011-2012 Meet 25% (8) of: < 100 beds Meet 15% (5) of:	2013-2014 Meet 50% (17) of: < 100 beds Meet 30% (10) of:	2015-2016 Meet 75% (26) of: < 100 beds Meet 60% (20) of:	2017 Meet substantially all of:
30. *Contribute data to a PHR* 31. *Record patient preferences (language, etc.)* 32. *Provide electronic access to patient-specific educational resources* 33. *Reporting of RHQDAPU quality measures through existing process*	*electronically* 30. *Contribute data to a PHR* 31. *Record patient preferences (language, etc.)* 32. *Provide electronic access to patient-specific educational resources* 33. *Medication reconciliation across settings of care (pilot)* 34. *Reporting of some RHQDAPU quality measures through EHR*	*Ray viewing)* 29. *Generate and transmit permissible discharge prescriptions electronically* 30. *Contribute data to a PHR* 31. *Record patient preferences (language, etc.)* 32. *Provide electronic access to patient-specific educational resources* 33. *Medication reconciliation across settings of care (if possible)* 34. *Reporting of some RHQDAPU quality measures through EHR*	*of care in EHR (substantially all departments)* 26. *Record physician assessment in EHR (substantially all departments)* 27. *Record physician notes in EHR (substantially all departments)* 28. *Multimedia/imaging integration (e.g., X-Ray viewing)* 29. *Generate and transmit permissible discharge prescriptions electronically* 30. *Contribute data to a PHR* 31. *Record patient preferences (language, etc.)* 32. *Provide electronic access to patient-specific educational resources* 33. *Medication reconciliation across settings of care* 34. *Reporting of all appropriate RHQDAPU measures through EHR*

Notes:

1. *ITALICIZED objectives from the HIT PC recommendations for 2013 and 2015*
2. *List Excludes proposed objectives on electronic insurance verification and electronic billing in all years, and medication reconciliation in 2011/2012 only.*