May 4, 2012

Submitted Electronically

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Re: Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2 Notice of Proposed Rulemaking (CMS-0044-P)

Dear Ms. Tavenner:

The Florida Hospital Association (FHA), on behalf of its more than 180 hospital and health system members, as well as nearly 1,200 individual members, appreciates the opportunity to offer comments on the Centers for Medicare & Medicaid Services' (CMS) notice of proposed rulemaking for Stage 2 of "meaningful use" under the Medicare and Medicaid electronic health record (EHR) incentive programs. The FHA fully supports the comments submitted by the American Hospital Association (AHA).

While the vast majority of hospitals – more than 80 percent – have not yet met Stage 1, due to both the high bar set and market factors, we are concerned that elements of the proposed rule for Stage 2 would stand in the way of a successful program to support widespread adoption by all hospitals. Many of the proposals put regulatory requirements ahead of actual experience with these technologies – an approach that will likely have unintended consequences. The Stage 1 requirements are challenging – further raising the bar in Stage 2 risks limiting the success of the Medicare and Medicaid EHR incentive programs. It also could unintentionally discourage providers from adopting EHRs if they do not believe they can meet the requirements.

As stated by AHA, the major concerns and recommendations related to the proposed rule pertain to the implementation of the Medicare penalty phase, the proposed timing and staging of meaningful use Stage 2, the specific objectives and measures for Stage 2, and the reporting of clinical quality measures through EHRs.

- We urge CMS to determine penalties for hospitals paid under the inpatient prospective payment system (PPS) using a reporting year that coincides with the payment year, as proposed for critical access hospitals. The proposed approach to implementing the penalties that begin in fiscal year (FY) 2015 is unacceptable because it bases penalties on performance in a prior year, generally with a two-year look-back. This policy unfairly accelerates the date by which PPS hospitals must meet the meaningful use requirements to avoid penalties. The law implies that penalties should apply in a given year if a hospital did not meet meaningful use in that year. In contrast, CMS is proposing that

penalties apply in a particular year if a hospital did not meet meaningful use two years prior to that year. This does not seem to meet the intent of the law.

In addition, the FHA opposes CMS's proposal to implement the Medicare eligible professional (EP) payment penalty based on a reporting period that is two years prior to the payment penalty year. The law requires Medicare payment penalties beginning in CY2015 for physicians and other EPs that fail to meet meaningful use.

- The FHA, following the comments of the AHA, appreciates the proposed one-year delay in the start of Stage 2, but we caution that the delay may not ensure adequate time to transition from Stage 1 to Stage 2 safely and without undue distortions to the market. The FHA concurs that the one-year delay in the start of Stage 2 will allow a somewhat more realistic timeframe between when the final rules are expected to be released and when hospitals must be meeting the Stage 2 objectives with newly certified products.

  We recommend two policies to ease the transition: a 90-day reporting period in the first year of Stage 2 and any subsequent stages, and a length of three years for each stage. Given the limited vendor capacity to work with providers, and the complex nature of the changes proposed, it is unrealistic to ask <u>all</u> hospitals to make the transition to be at Stage 2 on the <u>exact same day</u> as hospitals at Stage 1 upgrade to a new version of certification. This could pose a safety risk if implementations of sensitive clinical applications like computerized provider order entry (CPOE) and clinical decision support are rushed.

- The proposed requirements for meeting Stage 2 are not feasible for the majority of hospitals to achieve. Analysis by the AHA of the functional requirements in the proposed rule shows that, while the total number of objectives went down from 24 in Stage 1 to 20 in Stage 2, the actual number of functions embedded in those objectives increased by about 50 percent overall, from 49 functions in Stage 1 to 73 functions in Stage 2. When the Stage 2 requirements for meeting the core and menu set objectives are applied, the number of functions that are needed to achieve meaningful use increased from 43 functions in Stage 1 to 70 functions in Stage 2 - an increase of more than 60 percent. The proposed rule raises the bar significantly for Stage 2 compliance, and represents more than a 50 percent increase in actual requirements.

  To make Stage 2 more feasible and less burdensome, and to improve the predictability of changes to the program over time, we support AHA's recommendation that CMS apply the following policies to all of the objectives and measures for both hospitals and EPs:

  - Preserve the existing approach of a core set of required objectives accompanied by a menu set with limited choice among objectives.
  - Introduce all new objectives through the menu set.
  - Move menu items to the core at the same performance threshold set in Stage 1.
  - Remove measures that make the performance of hospitals and EPs contingent on the actions of others.

- We urge CMS to defer adding new hospital quality measures to the meaningful use program until Stage 3 so that Stage 2 can be used to make the process viable. Analysis by the AHA has shown that hospitals have encountered significant difficulty in using EHRs to report the clinical quality measures (CQMs) required for Stage 1, despite making large investments of financial and human resources.

Thank you for the opportunity to share our concerns and comments. Again, the detailed comments submitted by the AHA are reflective of the concerns of FHA and its members. If you have any questions, please contact me at kathyr@fha.org or via phone at (407) 841-6230.

Sincerely,

Kathy Reep
Vice President/Financial Services