American Health Information Management Association®

1730 M Street, NW, Suite 502
Washington, DC 20036

phone » (202) 659-9440
fax » (202) 659-9422
web » www.ahima.org

March 12, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–0033-P
PO Box 8013
Baltimore, Maryland 21244-8013

Re: File Code CMS-0033-P

Medicare and Medicaid Programs; Electronic Health Record Incentive Program (75 *Federal Register* 1844)

Dear Ms. Frizzera:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Health and Human Services (HHS) Centers for Medicare & Medicaid Services' (CMS') notice of proposed rulemaking (NPRM) for the electronic health record (EHR) incentive program as published in the January 13, 2010 *Federal Register* [75FR1844]. Our comments focus on those areas of particular relevance to the health information management (HIM) expertise.

AHIMA is a not-for-profit professional association representing more than 56,000 HIM professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and protecting healthcare information and data, while making it accessible to healthcare providers and appropriate researchers. AHIMA and its members also participate in a variety of projects with other industry groups and agencies of the HHS related to the use of secondary data for purposes including quality monitoring, reimbursement, public health, patient safety, and biosurveillance. Our detailed comments and rationale on the NPRM are outlined below. We are commenting on those areas that will have significant impact on the use, collection and reporting of health information and where we can lend our knowledge in these areas.

EHR TECHNOLOGY INCENTIVE PROGRAM
Subpart a—General Provisions
§ 495.4 Definitions.

II. Provisions of the Proposed Regulations; A. Definitions across the Medicare FFS, Medicare Advantage, and Medicare Programs

1. Definitions
c. Payment Year
AHIMA supports maintaining the payment years as outlined in the NPRM to reduce confusion and burden for Eligible Professionals (EPs) and Eligible Hospitals (EHs). For EHs it is prudent to align with their fiscal payment structure to receive the incentive payments.

e. EHR Reporting Period
AHIMA supports CMS' approach toward the EHR reporting periods, with the first period consisting of 90-days, and the follow on reporting periods lasting an entire year. We believe the approach toward payment periods following the initial reporting period should be uniform to enable EPs and EHs an opportunity to develop standardized and stable processes in meeting the reporting requirements.

Regarding when the reporting should begin within the first payment year, AHIMA endorses allowing EPs and EHs to select their start dates rather than CMS designating specific start dates. Also, we believe the earliest start date of reporting should be the first day of the reporting period. The flexibility in choosing when to initiate the reporting allows EPs and EHs with mature processes to begin immediately and enables participants who are not early adopters, additional time for preparation.

2. Definition of *Meaningful Use*
b. Common Definition of *Meaningful Use* under Medicare and Medicaid
AHIMA agrees with CMS that there is a strong level of interaction on meaningful use between the Medicare and Medicaid programs based upon the descriptions provided, and we also agree there is no compelling reason to develop disparate definitions for each program. Allowing States to include additional objectives to the definition of meaningful use or modify how the objectives are measured it would increase variability in the measurement and reporting processes and the reporting burden, thereby reducing comparability of the data. Therefore, we strongly concur with the proposed alignment of Medicare and Medicaid EHR incentive programs where possible.

c. Considerations in Defining Meaningful Use
AHIMA believes the proposed pathway to meaningful use as described in this section is reasonable in terms of deploying the program in stages. We concur with the Health Information Technology Policy Committee (HIT Policy Committee) Implementation Workgroup's recommendation 8.0, presented on February 17, 2010: "*CMS should advance its timetable for the release of future MU NPRMs in order to allow adequate ramp-up time for vendors and*

providers."[1] We agree with the workgroup's concern that vendors require lead time to develop systems and providers need time to integrate the new or modified systems into their clinical and administrative workflow. We must underscore the importance of ensuring the integration of clinical workflow and data capture processes. These functions are critical to the successful adoption, implementation, and meaningful use of EHRs.

We support the recommendations presented by the Meaningful Use Workgroup during the HIT Policy Committee meeting held on February 17, 2010. We believe CMS should create a "glide path" for Stage 2 and 3 meaningful use[2]. AHIMA supports the following Workgroup recommendations:

- Vendors need more time to develop appropriate functionality.
- Providers need more time to integrate it into clinical workflow.
- Recognize that CMS needs experience from Stage 1 implementation before finalizing Stage 2 and 3 recommendations; however, to the extent possible, CMS should consider publishing the Stage 2 Meaningful Use NPRM earlier than anticipated in December 2011.
- Strong signal of intentions related to future stages would be very helpful to make the realization of future expectations more feasible.

The NPRM uses the term "evidence-based order set" with no corresponding definition. We believe that without a definition guiding participants on the proper use it will leave an opportunity for interpretation and misunderstanding. We propose to use the following definition, "*Evidence-based orders sets are sets of orders for services or medications considered most effective for a given condition and are listed in the sequence that provides the most efficacies for treating the findings and obtaining the best results. They are based on published best practices, and are often more efficient and cost-effective than less-structured traditional approaches. These sets are incorporated into EHRs' CPOE and will prompt the physician when an order is entered to consider other tests and/or medications in addition to or in lieu of the original order entered*."

d. Stage 1 Criteria for Meaningful Use (2) Health IT Functionality Measures

Reporting flexibility - We understand the need to temper the level of requirements for reporting against the variability of EHR adoption. We recommend that CMS allow for greater flexibility within the reporting requirements. We support and align our recommendations with the HIT Policy Committee Implementation Workgroup that were presented on February 17, 2010. We agree there is a need for reporting requirement flexibility and to diverge from the "all-or-nothing" approach to achieving meaningful use. We also agree there is a need to promote the adoption of EHRs and supporting technology; nevertheless, eligible participants represent a large variability in terms of adoption, implementation, and usage rates.

We believe the HIT Policy Committee recommendation #12 "*Eligible professionals and hospitals should be given the flexibility to defer up to six meaningful-use criteria as described in the table below, but must meet all mandatory objectives"* provided by the Implementation Workgroup strikes the right balance for EPs and EHs, particularly during the Stage 1 reporting

[1] Paul Tang, Chair, "Proposed Recommendations on MU Notice of Proposed Rule Making" (presented to the HIT Policy Committee, Washington, DC, February 17, 2010).
[2] Ibid.

period. [3] By allowing participants to defer the completion of some of the criteria until stage 2, but not eliminate them completely strikes a balance and stills allows the opportunity to qualify for the program.

Feedback and timelines - We strongly encourage CMS to provide clarification on the reporting and feedback communication between the EPs and EHs thereby enabling a process for timely feedback on the accuracy of the content and reporting of the criteria. The information should include how CMS will accept and confirm receipt of the information, how problems will be supported and addressed, and the service level expectations for sending relevant feedback or benchmark information.

Parallel reporting - To minimize redundant reporting we recommend that the attestation process to submit the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) data be allowed to support the 'parallel' reporting requirements. We understand this is the intent during the electronic reporting periods however, it is not clear for Stage 1.

Attestation process - The NPRM proposes to have EPs and EHs demonstrate meaningful use of certified EHR technology for 2011 by attesting to the accuracy and completeness of the numerators and denominators for each applicable measure. We strongly propose that CMS ***eliminate the requirement for EPs attestation*** for the 2011 reporting period and delay reporting of any clinical quality data until CMS can electronically accept data. This recommendation is consistent with allowing delayed reporting by Medicaid providers until 2012, which is when the states are expected to have the infrastructure available to receive, store, and analyze clinical quality measure data.

Should CMS determine it is necessary to move forward with the attestation process, we believe the following must be addressed. AHIMA understands the need for a reporting process; however more information is needed for the attestation program to allow providers to decide when to begin participating. We strongly urge CMS provide additional information regarding:

1. *Reporting* - Clarify the details of the attestation process and ensure this process is convenient and reliable, but does not detract from the implementation of the electronic reporting process. We urge CMS to press forward expeditiously with developing the electronic reporting program. We encourage CMS to leverage current infrastructure such as the secure portal used for RHQDAPU reporting as this would not create additional burden for the EHs.
2. *Auditing and Validation* - We request that CMS ensure the audit and validation processes include timely responses and feedback when issues arise.
3. *Support infrastructure* - CMS should outline the support that will be provided in terms of a help desk, tools, reference manuals, and other supporting materials to support the reporting process.
4. *Review and appeal process* - The NPRM does not outline a review and appeal process for the reporting program, and we strongly believe this is a critical element to the success of the meaningful use incentive program. Currently, the RHQDAPU program allows participants an

[3] Ibid.

opportunity to appeal CMS' findings if there are problems identified. Within the RHQDAPU program, hospitals have 10 days to appeal to their Quality Improvement Organizations through a formal appeal process and structure. We recommend CMS leverage this process for the EHR incentive program.

Overall testing infrastructure - We encourage CMS to test the measures included for each payment period. For example, if 2011 EHR measure specifications are provided as of April 1, 2010, it is not clear when and how the specifications will be tested. We strongly believe that the specifications require some level of independent verification and validation and other mechanisms of evaluation.

Manual data collection - We support the recommendations presented by the Adoption/Certification Workgroup during the HIT Policy Committee held on February 17, 2010[4] concerning reporting metrics. The Workgroup highlighted the need for additional information on how to calculate metrics for items involving the percentage of *electronic* usage versus *manual* usage. We encourage CMS to consider for Stage 2 eliminating manual review of records and subjective judgments.

Department of Health and Human Services
Specifically, for each metric:

- Are rough estimates accepted or is the metric expected to be precisely calculated?
- Is manual review and counting of records expected, and if so, over what time period?
- Can a statistical process be used? For example, is it acceptable to review all encounters for a single week to extrapolate percentages?

AHIMA is concerned with the increased burden associated with the collection of numerator and denominator data called for in many of the measures requiring manual data collection. The number of admissions for hospitals or the number of unique encounters for the professional can be collected (generally outside the EHR system), but once the data collection occurs, further analysis is required to determine applicability to the measure, thus requiring additional burden to conduct this analysis and review.

Several of the HIT Functionality measures require a "one time or one test" demonstration, thus allowing eligible participants to meet the reporting criteria. AHIMA strongly believes this diverges from the true intent of the use of EHRs for patient care and it continues to support the need for a hybrid or paper record environment. Moreover, implementing and integrating EHRs into the clinical and administrative workflow should represent a holistic approach, not segmentation.

Table 1 and 2 - The tables below summarize AHIMA's comments regarding the specific EPs and EHs HIT Functionality objectives and measures.

[4] Paul Egerman, Co-Chair, "Comments on NPRM, IFR" (presented to the HIT Policy Committee, Washington, DC, February 17, 2010).

Table 1: HIT Functionality Measures—Eligible Professionals

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
Use CPOE	For EPs, CPOE is used for at least 80% of all orders	We believe that CPOE is a more advanced EHR application and is not appropriate for inclusion in Stage 1 criteria. We recommend the CPOE objective and measure be delayed to Stage 2. Further, we recommend that a measurement of 80 percent be based upon **unique patients** and demonstration of the ability to electronically transmit orders.
Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality	We propose that this objective become part of the criteria for e-prescribing, rather than being a separate objective or measure. We believe this is a function that can be accomplished through e-prescribing in these ambulatory situations.
Maintain an up-to-date problem list of current and active diagnoses based on ICD–9–CM or SNOMED CT	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data	While we support the use of problem lists and understand the need to rely on ICD-9-CM for Stage 1, the quality of problem lists can be expected to be highly variable due to non-standard system dependent solutions and how clinicians define problems. This can result in a tendency to rely heavily on ICD-9-CM or other coded data, which may not adequately express the patient's current and past diagnoses and other data required for a useful problem list. We recognize that problem lists can be critical drivers of other functionality in the EHR such as clinical decision support, patient reminders, quality measures, and the support of clinical information exchange between providers. We propose that problem lists not be generated from coded data entered by others as is sometimes the case in current practice, but rather that clinicians directly enter the appropriate information and as part of their workflow that can be converted to coded data for the above stated uses. This should be clearly stated in the rule by defining the verb *maintain* to mean *review* and *update*, as appropriate, at each visit by the healthcare provider. ICD-9-CM and/or ICD-10-CM code sets are acceptable as a short-term solution when healthcare providers are not yet ready to implement SNOMED CT® in EHR systems. Use of a classification offers some value in reuse of data for administrative purposes, including claims submission for reimbursement. Ultimately, AHIMA recommends use of SNOMED CT® for optimal clinical data capture and reuse of information captured in problem lists. We appreciate the evolution process and understand the limitations and variability the current options provide. The

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
		use of a classification system limits data mining for clinical research, quality of care measurement and communication between care providers and patients. *Please refer to Appendix A for a more detailed discussion of Problem Lists.
Generate and transmit permissible prescriptions electronically (eRx)	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	As mentioned previously, we propose that CMS incorporate the drug-drug, drug-allergy, drug-formulary checks objective into e-RX. Also, we suggest CMS to provide additional information regarding the measure for this objective. Please clarify whether this is ALL prescriptions or just EHR-based prescriptions, as there are potential increased data collection burdens if EPs are operating within a hybrid environment and need to report on the measure that has a denominator including written prescriptions.
Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of ‘‘none’’ if the patient is not currently prescribed any medication) recorded as structured data	We request clarification for situations when patients pay for their medication (for example, psychotropic drugs) in cash and request this information be excluded from their record.
Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of ‘‘none’’ if the patient has no medication allergies) recorded as structured data	No comment.
Record demographics • preferred language • insurance type • gender • race • Ethnicity • date of birth	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data	AHIMA supports this measure and the use of the Office of Management and Budget (OMB) standards for race and ethnicity. We suggest adding the data element for “zip code” in the recorded list of demographic information. This is an important demographic which can be utilized in treatment and disease management. We request clarification on the reporting requirements for the demographic data. For example, we are unclear if the measurement requires that all elements must be captured

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
		for the 80 percent of unique patients, or if it is acceptable if 80 percent of the patients have several of the elements and another portion of the universe of patients has other elements. The question is: Is the 80 percent requirement per demographic element or must 80 percent of the patients have ALL elements?
Record and chart changes in vital signs: • height • weight • blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2–20 years, including BMI	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2–20	No comment
Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have ‘‘smoking status’’ recorded.	No comment
Incorporate clinical lab test results in to EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	Today, many labs do not have the ability to electronically transmit structured test results, Therefore we propose that laboratories be required by CMS to use standards-based submission of data to EHRs, and that this objective be delayed until Stage 2. Please define if this addresses internal and external labs.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.	Generate at least one report listing patients of the EP or eligible hospital with a specific condition	No comment
Report ambulatory	For 2011, provide aggregate	Comments to this point are presented below in section “*b. Requirements for the*

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
quality measures to CMS or the States	numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule. For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule.	*Submission of Clinical Quality Measures by EPs and Eligible Hospitals*" of this letter.
Send reminders to patients per patient preference for preventive/follow up care.	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over	No comment
Implement 5 clinical decision support rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).	No comment
Check insurance eligibility electronically from public and private payers.	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital.	We propose removing "Check insurance eligibility electronically from public and private payers." Insurance eligibility is a registration administration function, and not a component of many basic EHR functionalities. It is also not directly related to treatment or improvements in quality or safety of care. As stated in the proposed rule, electronically checking insurance eligibility is addressed in the HIPAA regulations. Further requirements should not be a part of meaningful use, but rather left to anticipated forthcoming statutory requirements regarding administrative simplification.
Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital.	Claims submission is a claims processing or patient accounting function supporting billing and payment, and is not a component of EHR functionality. Nor is it directly related to treatment or improvements in quality or safety of care. Also, all payers do not yet accept electronic claims (for example, workers compensation) and the EP would have no ability to ensure 80 percent are received in this manner. While we support administrative simplification and use of electronic claims, we propose that this objective not be part of meaningful use.

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request.	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.	The information presented in parentheses provides a short list of information that must be provided to the patient. We request clarification whether this is a complete list or just an example of what must be included at a minimum to the patient. The 48 hour window to provide patients with an electronic copy of health information is an extremely aggressive timeframe. There are many variables that would impact the response period, such as the completion of test results, thus impacting the availability of the data being requested. We understand there are state laws that address the timeframes for responding to information requests, however we strongly encourage and promote the migration toward a uniform response period across the states to ensure consistency in this process. We request further information regarding the expectation for "electronic copy" to the patient in terms of the type of media. During stage 1 and possibly other stages of meaningful use , there will also be a transition period where some health information is still on paper and this paper may need to be scanned in order to get it into an electronic format. We propose that this measure explicitly limit electronic copies of health information to that information which has been created electronically. Finally, we are concerned that calculating the denominator for this measure will require logging and measuring response times and therefore be burdensome and require additional administrative work for EPs.
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information	AHIMA requests further clarification on the term "electronic access" as described in the objective and corresponding measure. This could represent a variety of electronic methods and may be left to interpretation and unsure about expectations from the EP. The information presented in parentheses provides a short list of information that must be provided to the patient. However we are unclear if this is the complete list or an example of what must be included at a minimum to the patient. We request clarification.

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
information being available to the EP.		Historic records that have not been converted to electronic format, or entire medical records beyond the Stage 1 patient-engagement information types, should not be subject to the expectation for online access in Stage 1. AHIMA also noted an inconsistency in the information presented for this OBJECTIVE. Table #2 indicates the 96 hours for the objective. However, the description of the measure/objective on p.1864 makes no mention of the 96 hours. Therefore we request that CMS align the information that resides in the table with the description/text. We would also recommend that CMS add the term *secure* to the *timely electronic access* as noted in the objective and measure. We also suggest that CMS modifies the timeframe from 96 hours for access to health information to allow for variations in schedules, technical issues to be addressed, and time for collating the data into the EHR.
Provide clinical summaries for patients for each office visit.	Clinical summaries are provided for at least 80% of all office visits.	Much of the health information produced by EPs such as Opthamologists and Otolaryngologists are depicted through drawings and sketches of the patient's eyes and ears to demonstrate the clinical problem being discussed to record their treatments. This information will be a challenge to capture electronically and we request further clarification from CMS regarding the expectation of these types of providers.
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	CMS does not provide information regarding those situations where there may not be the ability to exchange data with another EP if they are not ready to exchange data. We request clarification on this issue of when one EP is ready to exchange and others in their exchange community are not. What is the solution for meeting this requirement? AHIMA recommends the solution for this issue be similar to the one provided for the objective "*Capability to submit electronic data to immunization registries and actual submission where required and accepted*." An alternative suggestion for any of the transaction testing requirements would be for CMS to open and operate a testing site where EPs could submit a transaction and receive a report as to whether or not it was accepted.
Provide summary care record for each transition of care and	Provide summary of care record for at least 80% of transitions of care and referrals.	We request additional information regarding whether the summaries must be provided within a certain number of hours or days.

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
referral.		CMS does not provide details regarding how this summary of care will be provided. Currently, it is unclear what type of electronic media will be acceptable to meet this requirement and meet the needs of the patient or the subsequent provider. We request additional clarification for this objective and measure.
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	We request clarification as to whether this measure includes or excludes self-administered and/or self-prescribed medications. Transition of care—Based upon the description provided by CMS on page 1858 (upper left column) we suggest the term be separately defined for EPs and EHs. Our suggested wording includes the following: **EP**—Transition of care is defined as a permanent transfer from one EP to another unrelated (not in the same group) physician (EP or non-EP) in an outpatient setting. **EH**—Transition of care is defined as a permanent transfer of a living patient from the EH to another hospital (EH or non-EH), long-term care facility, inpatient rehabilitation facility, or an ambulatory setting (home, outpatient rehabilitation, assisted living, and the like). As the definition reads now, our understanding is that a *transition* could mean a partner covering the weekend for another partner in the hospital, OR a transfer from one physician to a consultant in the same group to assess a problem, OR a transfer from the hospital to another hospital for a procedure where the patient is returned the same day, OR a transfer from the hospital to home. Now, this complicates medication reconciliation, because if an EH does transfer a patient for a procedure and the patient is returned the same day, the medication reconciliation should occur. As for the examples regarding EPs above, we do not believe this is necessary.
Capability to submit electronic data to immunization registries and actual submission where required	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries	We do not believe that conducting one test of this technological capability is the most appropriate use of an EH's focus of time and resources. We recommend CMS change the measure to just submit electronic data to immunization registries (not a one-time test) and this criterion will be met through the reporting process.

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
and accepted		
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically).	We do not believe that conducting one test of this technological capability is the most appropriate use of an EH's focus of time and resources. We recommend CMS change the measure to just submit electronic data to public health agencies (not a one-time test) and this criterion will be met through the reporting process.
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary.	AHIMA supports the recommendation presented by the HITPC Privacy and Security Workgroup on February 17, 2010[5] where the workgroup was explicit in recommending that CMS: • Make clear that for EPs and Hospitals who have never conducted a HIPAA security risk analysis, the requirement is to *conduct* such an analysis (not review). The option to *review* risk analyses should only be for those entities that recently conducted a security risk analysis and have not added new HIT capabilities. • Provide guidance to EPs and hospitals on how to conduct an appropriate security risk assessment. • Clarify what is meant by "implement security updates as necessary."
ADD Objective/Measure to Stage 1 MU—Document a progress note for each		AHIMA strongly encourages CMS to insert the objective regarding progress notes into the meaningful use measurement criteria as this helps to tell the story of the patient. Without this key data point, it misses nuances of patient care and is a fundamental workflow issue. We support the recommendations presented by the HITPC Implementation Workgroup on February 17, 2010[6], where the Committee strongly

[5] Deven McGraw, Chair, "Comments/Recommendations on Meaningful Use Proposed Rule; Standards IFR; Future Security Policy/Standards Priorities" (presented to the HIT Policy Committee, Washington, DC, February 17, 2010).
[6] Ibid., HIT Policy Committee Implementation Workgoup

Objectives	Stage 1 Measures	Eligible Professionals—Issues/Comments and Recommendations
encounter.		believes progress notes are a core function of the EHR and should be included. We agree with their supporting statements with respect to the reasons listed for delivering high quality care and coordination of care: • Handwritten medical records not only take more time to decipher, their illegibility often obscures important information • Information that is not entered electronically at the point of care is lost forever, thus rendering the record less complete. • Hybrid systems (part electronic, part paper) cause fragmentation of the record and inefficient workflow • Maintaining progress notes on paper impedes patients' access to this information because there is no structured way to provide patients with context to those data. • Sharing electronic progress notes is fundamental to successful care coordination. • Textual progress notes provide significant information about the patient that is not captured in the structured format elsewhere. Providers use these to know the patient as a human being, and patient focus groups suggest the best way to improve quality of care is for personal clinicians to "really know me."[7] As keepers of the patient story, we recommend CMS ensure this is part of the certification criteria for EHRs as well.

Table 2: HIT Functionality Measures—Eligible Hospitals

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
Use CPOE	For eligible hospitals, CPOE is used for 10% of all orders	We believe that CPOE is a more advanced EHR application and is not appropriate for inclusion in Stage 1 criteria. We recommend the CPOE objective and measure be delayed to Stage 2. Further, we recommend that a measurement of 80 percent be based upon **unique patients** and demonstration of the ability to electronically transmit orders.

[7] Ibid., HIT Policy Committee Implementation Workgroup

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality	No comment
Maintain an up-to-date problem list of current and active diagnoses based on ICD–9–CM or SNOMED CT	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data	While we support the use of problem lists and understand the need to rely on ICD-9-CM for Stage 1, the quality of problem lists can be expected to be highly variable due to non-standard system dependent solutions and how clinicians define problems. This can result in a tendency to rely heavily on ICD-9-CM or other coded data, which may not adequately express the patient's current and past diagnoses and other data required for a useful problem list. We recognize that problem lists can be critical drivers of other functionality in the EHR such as clinical decision support, patient reminders, quality measures, and the support of clinical information exchange between providers. We propose that problem lists not be generated from coded data entered by others as is sometimes the case in current practice, but rather that clinicians directly enter the appropriate information and as part of their workflow that can be converted to coded data for the above stated uses. This should be clearly stated in the rule by defining the verb *maintain* to mean *review* and *update*, as appropriate, at each visit by the healthcare provider. ICD-9-CM and/or ICD-10-CM code sets are acceptable as a short-term solution when healthcare providers are not yet ready to implement SNOMED CT® in EHR systems. Use of a classification offers some value in reuse of data for administrative purposes, including claims submission for reimbursement. Ultimately, AHIMA recommends use of SNOMED CT® for optimal clinical data capture and reuse of information captured in problem lists. We appreciate the evolution process and understand the limitations and variability the current options provide. The use of a classification system limits data mining for clinical research, quality of care measurement and communication between care providers and patients. *Please refer to Appendix A for a more detailed discussion of Problem Lists.

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of ‘‘none’’ if the patient is not currently prescribed any medication) recorded as structured data	We request clarification for situations when patients pay for their medication (for example, psychotropic drugs) in cash and request this information be excluded from their record.
Maintain active medication *allergy* list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of ‘‘none’’ if the patient has no medication allergies) recorded as structured data	No comment
Record demographics: • preferred language • insurance type • gender • race • ethnicity • date of birth • date and cause of death in the event of mortality	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data	AHIMA supports this measure and the use of the Office of Management and Budget (OMB) standards for race and ethnicity. We suggest adding the data element for “zip code” in the recorded list of demographic information. This is an important demographic which can be utilized in treatment and disease management. We request clarification on the reporting requirements for the demographic data. For example we are unclear if the measurement requires that all elements must be captured for the 80 percent of unique patients, or will it be acceptable if 80 percent of the patients have several of the elements and another portion of the universe of patients has other elements. The question is: Is the 80 percent a requirement per demographic element, or must 80 percent of the patients have ALL elements?
Record and chart changes in vital signs: • height	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure	We believe the recording of the patients’ height, weight, blood pressure, and BMI and the plotting of growth charts for children, including BMI, is a reasonable requirement for EP, but not necessarily for EH. We do not believe the recording of growth charts and BMI is a reasonable expectation for EH in Stage 1—and would

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
• weight • blood pressure • Calculate and display: BMI. • Plot and display growth charts for children 2–20 years, including BMI.	and BMI; additionally plot growth chart for children age 2–20	probably not yield any meaningful health outcomes data because the vast majority of patients ages 2 to 20 are not hospitalized on a regular basis. We recommend the introduction of growth charts and BMI for patients ages 2 to 10 as a requirement for EH be moved to stage 2 or later.
Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have ‘‘smoking status’’ recorded	No comment
Incorporate clinical lab test results in to EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	Today, many labs do not have the ability to transmit structured test results electronically. Therefore, we propose that laboratories be required by CMS to use standards-based submission of data to EHRs, and that this objective be delayed until Stage 2. Please define if this addresses internal and external labs.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.	Generate at least one report listing patients of the EP or eligible hospital with a specific condition	We encourage CMS to provide a list of core data elements that must be generated and could be supplemented based upon patient population being reported.
Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule. For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule.	Comments to this point are presented below in section “*b. Requirements for the Submission of Clinical Quality Measures by EPs and Eligible Hospitals*” of this letter.
Implement 5 clinical	Implement 5 clinical decision	No comment

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules.	support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3)	
Check insurance eligibility electronically from public and private payers.	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital.	We propose removing "Check insurance eligibility electronically from public and private payers." Insurance eligibility is a registration or admission administrative function, not a component of basic EHR functionality, and is not directly related to treatment or improvements in quality or safety of care. As stated in the proposed rule, checking insurance eligibility electronically is addressed in the HIPAA regulations. Further requirements should not be a part of meaningful use, but rather, are left to anticipated forthcoming statutory requirements regarding administrative simplification.
Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital.	Claims submission is a claims processing or patient accounting function supporting billing and payment, and is not a component of EHR functionality. Nor is it directly related to treatment or improvements in quality or safety of care. Also, all payers do not yet accept electronic claims and the EP would have no ability to ensure that 80 percent are received in this manner. While we support administrative simplification and use of electronic claims, we propose that this objective not be part of meaningful use.
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request.	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.	The information presented in parentheses provides a short list of information that must be provided to the patient. We request clarification whether this is a complete list or just an example of what must be included at a minimum to the patient. The 48 hour window to provide patients with an electronic copy of health information is an extremely aggressive timeframe. There are many variables that would impact the response period, such as the completion of test results, thus impacting the availability of the data being requested. We understand there are state laws that address the timeframes for responding to information requests, however we strongly encourage and promote the migration

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
		toward a uniform response period across the states to ensure consistency in this process. We request further information regarding the expectation for "electronic copy" to the patient in terms of the type of media. During stage 1 and possibly other stages of meaningful use, there will also be a transition period where some health information is still on paper and this paper may need to be scanned in order to get it into an electronic format. We propose that this measure explicitly limit electronic copies of health information to that information which has been created electronically. Finally, we are concerned that calculating the denominator for this measure will require logging and measuring response times and therefore be burdensome and require additional administrative work for EPs.
Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it.	AHIMA requests additional clarification regarding this objective/measure. CMS has not defined which electronic media can be used to supply an electronic copy to the patient. We encourage CMS to be consistent with the approach toward electronic media and copies that must be provided to the patient. Please refer to the EP objective, "*Provide clinical summaries for patients for each office visit*" where it states which type of media to leverage for the information. The information presented in parentheses provides a short list of information that must be provided to the patient. However, we are unclear if this is the complete list or an example of what must be included at a minimum to the patient. We request clarification. Additionally, many organizations can provide discharge instructions at time of discharge. However, if "procedures" refer to notes related to operative procedures that occurred during the patient's hospitalization, they may not be available due to dictation and transcription activities and timelines. We request clarification of the term *procedures* should be further provided to mean "those procedures that the patient must follow after discharge to attend to any residual conditions that need to

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
		be addressed personally by the patient, home care attendants, and other clinicians on an outpatient basis."
Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	Since organizations will change to EHRs at different cycles, demonstrating this ability will be restricted to between only those that have EHRs and those where connectivity and exchange is support by interoperability. CMS does not provide information regarding those situations lacking the ability to exchange data with another EP if they are not ready to exchange data. We request clarification on this issue of when one EP is ready to exchange and others in their "exchange community" are not. What will the resolution be for meeting this requirement? AHIMA recommends the solution for this issue be similar to the one provided for the objective "*Capability to submit electronic data to immunization registries and actual submission where required and accepted*."
Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals.	We request additional information regarding whether the summaries must be provided within a certain number of hours or days. CMS does not provide details regarding how this summary of care will be provided. The expectation is unclear with regard to what type of media this information will be presented in to the patient or to the subsequent provider. We request additional clarification for this objective and measure.
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	We request clarification as to whether this measure includes or excludes self-administered and self-prescribed medications. Transition of care—Based upon the description provided by CMS on page 1858 (upper left column), we suggest the term be separately defined for EPs and EHs. Our suggested wording includes the following: **EH**—Transition of care is defined as a permanent transfer of a living patient from the EH to another hospital (EH or non-EH), long-term care facility, inpatient rehabilitation facility, or an ambulatory setting (home, outpatient rehabilitation, assisted living, or the like). **EP**—Transition of care is defined as a permanent transfer from one EP to another unrelated (not in the same group) physician (EP or non-EP) in an outpatient setting.

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
		Our understanding as the definition reads now, a transition could mean a partner covering the weekend for another partner in the hospital OR a transfer from one physician to a consultant in the same group to assess a problem OR a transfer from the hospital to another hospital for a procedure where the patient is returned the same day OR a transfer from the hospital to home. Now, this complicates medication reconciliation because if an EH does transfer a patient for a procedure and the patient is returned the same day, the medication reconciliation should occur. As for the examples regarding EPs above, we do not believe this is necessary.
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries	We do not believe that conducting one test of this technological capability is the most appropriate use of an EH's focus of time and resources. We recommend CMS change the measure to just submit electronic data to immunization registries (not a one-time test) and this criterion will be met through the reporting process.
Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically).	We do not believe that conducting one test of this technological capability is the most appropriate use of an EH's focus of time and resources. We recommend CMS change the measure to just submit electronic data to public health agencies (not a one-time test) and this criterion will be met through the reporting process.
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible	We do not believe that conducting one test of this technological capability is the most appropriate use of an EH's focus of time and resources. We recommend CMS change the measure to just submit electronic data to public health agencies (not a one-time test) and this criterion will be met through the reporting process.

Objectives	Stage 1 Measures	Eligible Hospitals—Issues/Comments and Recommendations
	hospital submits such information have the capacity to receive the information electronically).	
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security reisk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary.	AHIMA supports the recommendation presented by the HITPC Privacy and Security Workgroup on February 17, 2010[8], where the workgroup was explicit in recommending that CMS: • Make clear that for EPs and Hospitals who have never conducted a HIPAA security risk analysis, the requirement is to *conduct* such an analysis (not review). The option to *review* risk analyses should only be for those entities that have recently conducted a security risk analysis and have not added new HIT capabilities. • Provide guidance to EPs and Hospitals on how to conduct an appropriate security risk assessment. • Clarify what is meant by "implement security updates as necessary."

[8] Ibid., HIT Policy Committee Privacy and Security Workgroup

§ 495.6 Meaningful use objectives measures for EPs, eligible hospitals, and CAHs.

II. Provisions of the Proposed Regulations; A. Definitions Across the Medicare FFS, Medicare Advantage, and Medicare Programs; Sections 4101(a) and 4102(a)(1) of HITECH Act: Reporting on Clinical Quality Measures Using EHRs by EPs and Eligible Hospitals

b. Requirements for the Submission of Clinical Quality Measures by EPs and Eligible Hospitals

Eligible Hospitals
AHIMA supports the inclusion of clinical quality measures as part of the meaningful use criteria for FY 2011 if CMS would consider reducing the measures for EHs to those measures that have electronic measure specifications and have been included in the RHQDAPU program and retooled for electronic submission. These measures would be ones with which hospitals are most familiar and equipped to deal with, allowing them to implement electronic versions sooner. This also allows hospitals and vendors to have sufficient time to review, implement, and test specifications.

CMS should also ensure that measure specifications include valid value set options that align with all allowable vocabulary standards for Stage 1 meaningful use. For example, the electronic measure specification information cited in the NPRM contains a value set for Ischemic Stroke defined by SNOMED-CT® codes. The Standards and Certification Interim Final Rule (IFR) indicates the vocabulary standard for problem lists in stage 1 meaningful use includes the "applicable HIPAA code set required by law (i.e., ICD-9-CM) or SNOMED CT®." As a result, the measure specifications should include both a value set for Ischemic Stroke using ICD-9-CM and a value set for Ischemic Stroke using SNOMED CT® to ensure unambiguous interpretation of the value sets and alignment with all allowable Stage 1 vocabulary standards.

c. Statutory Requirements and Other Considerations for the Proposed Section of Clinical Quality Measures Proposed for Electronic Submission by EPs or Eligible Hospitals

Eligible Providers
The NPRM specifies for the 2012 payment year clinical quality measures for EPs will be posted on CMS' Web site on or before April 1, 2011. We are concerned the nine month period will not allow adequate time for vendors to integrate measure specifications into EHR products and product updates; have provider work flows change to ensure that the data is collected in the EHR; be thoroughly tested by EPs; and have necessary training completed by the clinical and non-clinical staff supporting the EP. We believe that a *minimum* of 12 months is required to post the specification documents for the EP implementation process.

Moreover, CMS is also proposing to move ahead with 2011 reporting without the requisite measure specifications in this first year. We believe the lack of information will result in confusion and frustration, be inefficient for many EPs, and will also result in data of limited utility and comparability. We propose that CMS delay implementation of any measure for which

specifications have not yet been developed and posted. Lack of measure specifications is yet another reason to eliminate the attestation requirement (it is difficult to know whether the data is accurate and complete without the specifications) for 2011 and until CMS is able to receive the data electronically and can make determinations about the validity of the data.

Eligible Hospitals
CMS proposes a nine month timeframe between the publication of the electronic specifications to the clinical quality measure EHR reporting period. There is concern that this window, especially in the initial years of implementation, is too small for vendors to ensure their systems have the required capability to capture the data and to update and certify systems, while still allowing time for hospitals to implement and report out the measures.

We encourage CMS to consider expanding this window for publishing the electronic specifications for clinical quality measures from 9 to at least 12 months for the first years of implementation, and then reexamine the timeframes based on user experience and feedback. We also believe that CMS should consider creating a stakeholder group or partnering with external groups to establish an ongoing mechanism to pilot test proposed new measures with a public comment period prior to releasing final specifications.

CMS lists the criteria by which they select clinical quality measures for implementation, including those that align with other reporting systems such as RHQDAPU and CHIP. Through this process it addresses CMS and HHS policy priorities and known gaps in quality of care. We believe this is a reasonable approach consistent with their stance for both IPPS and OPPS quality reporting requirements.

Although HITECH does not specifically require the use of NQF-endorsed measures, we urge CMS to align with other measure retooling and testing efforts, such as those being conducted by NQF. This would allow for an expanded process of development and testing and a public comment period to ensure the feasibility of data collection and reporting through current EHR technology.

Final specifications for the EH clinical quality measures are being targeted by April 1, 2010. CMS also notes that final specifications may be different from current specifications or those used for testing of EHR-based data submission. We are concerned about the ability to assess the feasibility of these measures, especially for the 2011 payment year, when the specifications will not be available until after the responses to the proposed rule are due.

e. Clinical Quality Measures Reporting Criteria for EPs
CMS intends to narrow down each proposed measure set for specialties to a required subset of three to five measures based on the availability of electronic measure specifications. In conjunction with our comments above, we support this plan to limit the number of clinical quality measures and believe that it is reasonable (again with the caveat that CMS delay the requirement to report or attest until it is has the capability to receive the data electronically in 2012 or beyond).

CMS proposes to require EPs to select a specialty measures group, on which to report all applicable cases for each of the measures for the 2011 and 2012 reporting period. The same specialty measures group selected for the first payment year would be required for reporting for the second payment year. AHIMA agrees it is appropriate to report on the same two measure groups in consecutive years to provide the best data to CMS. We suggest that CMS accept Medicare and Medicaid during the same year. If CMS still intends to accept initial reporting for Medicare in 2011 and for Medicaid in 2012, then EPs reporting to Medicaid should also be required to report on the same measure groups in 2013 to allow two consecutive years of Medicaid reporting for statistical and data analysis purposes.

The NPRM describes those EPs, who believe that no specialty listed in Tables 5-19 are applicable to them, as potentially exempt from selecting and reporting on a specialty measure group. EPs that are so-designated will be required to attest to this fact and not required to report information on clinical quality measures from a specialty group for 2011 or 2012. We encourage CMS to reconsider this as an option and recommend that CMS allow the EPs to report on those measures in a group from Tables 5-19 that are applicable to their patient population and attest to CMS or the State to the inapplicability of a measure(s) in the group. This should only be acceptable if there is no measure group from Tables 5-19 in which all clinical quality measures within any of the groups apply to the EPs patient population.

f. Proposed Clinical Quality Measures for Electronic Submission by Eligible Hospitals
Table 21 within the NPRM proposes alternative Medicaid measures focusing primarily on the pediatric population. Unfortunately, none of these measures have any current electronic specification information that enables us to determine the feasibility of capturing this data in an EHR. Also, the Agency for Healthcare Research and Quality (AHRQ) measures (NQF # 0348 and 0362) appear to rely on ICD-9-CM diagnosis codes, we request further clarification on how valid a test of EHR capability these measures are.

An additional concern for several of the proposed clinical measures and the alternative Medicaid measures is they appear focused mainly on claims-based data (for example, Readmission Index, AHRQ Iatrogenic Pneumonia, and Foreign Body left after procedure) and we are unsure how these measures demonstrate the capabilities of an EHR. We encourage CMS to reconsider the use of these measures to demonstrate meaningful use of EHRs.

h. Proposed Reporting Method for Clinical Quality Measures for 2011 and 2012 Payment Year

(1) Reporting Method for 2011 Payment Year
AHIMA encourages CMS to consider including information regarding the provision of a Web site with an easily accessible form for entering information required by the attestation provision (if CMS chooses to retain the attestation process). We recommend CMS consider using the same "CMS-designated portal" for attestation reporting as described under reporting methods for 2012. The attestation process should be clearly documented and contain detailed instructions for completion so all required information is uniformly submitted.

The NPRM states "Medicare EPs and hospitals attest to the use of a certified EHR system to capture the data elements and calculate the results for the applicable clinical quality measure." We request further clarification regarding this statement to allow the use of "a certified EHR system or EHR module" to support the calculation of quality measure results. Some hospitals currently use third party systems to submit data for the RHQDAPU program and they may prefer to continue using their third party vendors to calculate the results, pending certification. The IFR for Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology suggests that quality measure reporting services or software programs qualify as an EHR Module and could be certified to support these processes. We don't believe it's feasible to assume all EHR systems will provide analytic reporting capabilities, especially in the short term.

(2) Reporting Method for 2012

We endorse the interpretation of "redundant or duplicative reporting" to mean requiring the reporting of data on the same clinical quality measure separately for two or more quality reporting programs under Medicare. We are appreciative of the requirement to only report to the EHR incentive program and thus satisfy all other parallel Medicare reporting requirements. This will significantly reduce the data collection and reporting burden for HIM professionals. In light of these acknowledgements, we request clarification on how this process will be managed.

The NPRM notes the Secretary's authority to collect summarized clinical quality measures is not just limit Medicare and Medicaid data. We support the notion that hospitals will capture this data in their EHR regardless of payer. Having all payer or health plan data for quality measures provided in a uniform manner would reflect true quality results across all patients, regardless of severity, based on age.

We appreciate that CMS provides three methods for electronically submitting the required clinical quality measure information. However, it does not appear feasible that all three methods will be adopted if made available on April 1, 2011, for use during payment year 2012. In order to have a choice between all three methods, we encourage CMS to provide specifications earlier than April 1, 2011. This will afford EHR vendors the time needed to make available to participating hospitals as many of these methods as possible. Some consideration has been given to the proposed three methods:

> *CMS-designated portal*—The option described here is one that is currently in use for some CMS data reporting programs (that is, RHQDAPU), and participants report success in using this functionality. By 2012 this process would mature and enable current users to leverage a process they are more familiar with, and would streamline and reduce reporting burden rather than necessitating a new function. We endorse CMS' selection of this method for one of the reporting options.
>
> *Health Information Exchange (HIE)/Health Information Organization (HIO)*—The HIE/HIO infrastructure encourages integration of health data among entities, it remains a relatively immature process within the healthcare community, and is evidenced by the fact the ability to collect the data has not been defined in the NPRM or through other resources. We encourage

CMS to consider postponing this option until Stage 2, or when CMS is able to accept and manage the incoming measurement data.

Registries—Registries have been in use for quite some time and were more recently proposed as an alternative reporting method for measure reporting initiatives such as PQRI, we support this reporting method with some reservations. Registries are typically proprietary solutions that offer services supporting reporting requirements. This could generate additional costs for participants as they leverage the use of registries for reporting purposes.

We request further clarification regarding the structure and processes for alternative reporting methods. Some questions we're considering:

1. Are these methods to be used in lieu of the data submission methods?
2. Can participants choose one method for one reporting period and another method for a subsequent one?
3. Do participants have the ability to choose different reporting methods for the different measures? What data would be reported? Is the data set different from the information required for "data submission"?

§ 495.8 Demonstration of Meaningful Use Criteria

II. Provisions of the Proposed Regulations; A. Definitions across the Medicare FFS, Medicare Advantage, and Medicare Programs;

4. Demonstration of Meaningful Use
AHIMA supports CMS' approach toward demonstration of meaningful use through attestation by EHs. We believe there is much more information that must be provided on the attestation process as described on page 4 of this response letter. In theory this is a thoughtful first step at trying to meet the requirements, but for EHs to fully engage in this effort CMS must provide clarification sooner rather than later. As outlined in the proposed rule, page 1903, CMS states, "We will issue further instructions on the specifics for submitting attestation through established outreach venues." Due to the depth and breadth of this program we encourage CMS to provide as much detail as soon as available.

a. Common Methods of Demonstration in Medicare and Medicaid
We endorse CMS' proposal to create a common method for demonstrating meaningful use as it will make the overall process less confusing for EPs that would like to switch programs and for hospitals participating in both initiatives.

b. Methods for Demonstration of the Stage 1 Criteria of Meaningful Use
We endorse CMS' proposal of establishing a uniform approach toward the demonstration of meaningful use. We are concerned about the use of claims-based reporting as described in this section of the rule for attestation purposes. Overall, we are concerned that an attestation process does not allow for the capability of CMS to validate this data, thereby limiting its use and stated purpose of benchmarking among EPs as indicated on p. 1890 of the NPRM.

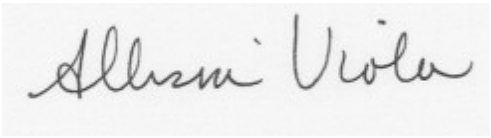
6. Hospital-Based Eligible Professionals
CMS outlines the total incentive payment for EPs is based on total inpatient services, and as a result of this, hospitals with a large outpatient department will not receive a higher incentive payment. AHIMA is concerned that hospital investment in their outpatient primary care sites is likely to lag behind their investment in their inpatient EHR systems. AHIMA also believes that excluding hospital outpatient department neglects the need for continuity of care and ignores the practice of medicine at many tertiary or university-based healthcare systems.

We understand and endorse the proposal for hospitals to initially qualify using inpatient data. However, we suggest that hospital outpatient services be included in future rules for Stage 2 and 3 meaningful use requirements, to ensure that outpatient EHR development does not languish. Hospital systems often install EHR products in outpatient settings in addition to inpatient settings, and many times start EHR implementation in outpatient settings due to the complexity of inpatient settings. We anticipate there will be a burden on HIM if hospitals are forced to choose to focus on inpatient areas only and not invest in outpatient areas, leaving facilities with a hybrid record. We strongly encourage future consideration by CMS to address outpatient services for the incentive payments. We also request further clarification on the outpatient services and what their role is within the overall incentive program as this is discussed infrequently within the NPRM.

While AHIMA understands that the underlying ARRA-HITECH legislation did not include extending the incentive program to long-term care and safety nest providers, we strongly urge CMS and Congress to amend this exclusion. If the United States is to build a patient-centered electronic healthcare system then it must include all providers and especially long-term care providers that are directly involved in the continuity of care. Exclusion of providers is directly contrary to a patient-centered concept and to other health reform concepts calling for bundling of care and the measurement of quality and outcomes across the spectrum of healthcare.

AHIMA appreciates the thoughtfulness that went into writing the NPRM on meaningful use. If we can provide further information, or if there are any questions regarding this letter and its recommendations, please contact me at (202) 659-9440, through allison.viola@ahima.org, or via AHIMA's vice president, policy and government relations, Dan Rode, at (202) 659-9440, or dan.rode@ahima.org. If we can be of further assistance to you as you continue to explore the meaningful use definition and standards, we welcome the opportunity to provide support.

Sincerely,



Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations

Appendix

The detailed discussion below refers to the objective: Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT and corresponding Measures for EPs and EHs.

A well-designed problem list functions as a table of contents for a health record and plays a key role in communication between care providers and patients. Records organized around current problems enable efficient information retrieval. Problem lists are often multi-disciplinary and include more than just diagnostic statements in order to capture a more complete picture of the patient status. Codification of problem lists enables interoperability and data mining for a variety of clinical needs and administrative use during the care process.

The vocabulary used to express problems using standard code sets may depend on type of information stored in this section of the record and the availability of the code set.

The Interim Final Rule allows for use of the International Classification of Diseases ICD-9-CM (2013 - ICD-10-CM) or the use of SNOMED CT® with eventual migration to SNOMED CT® in 2015. Each vocabulary is designed for a different purpose and each has limitations that must be considered.

Codification of problem lists enables interoperability and data mining for other purposes, such as quality of care measurement and administrative use, including claims submission for reimbursement. A classification system (ICD) categorizes diseases and health problems by assigning codes to the greatest degree of specificity possible at the end of an encounter. Conventions and guidelines for use require conditions integral to the disease process not receive separate codes. It is well suited for confirmed diagnoses for administrative reporting and other types of secondary use where it is desirable to use the category structure to capture similar conditions. Residual categories are available for diseases or reasons for care with descriptions that are not meaningful for communication between the provider and the patient.

Problem lists are rarely the same as a final diagnostic list used for claims submission since they are populated and used during the care process and subject to change as new problems arise and others are resolved. In addition to diagnoses, problem lists may include physiologic signs, symptoms, social factors, health risks, functional status, abnormal test results or other problems affecting care that are not optimally expressed in a classification of diseases. Conditions integral to a disease process are not separately assigned a code in a classification system, making it useful for statistical use and claims submission but limiting for clinical use.

Classification systems are able to be applied, without electronic support, to problem lists by using a manual code assignment process. Healthcare providers already use ICD for claims submission and billing, so no additional implementation is required.

Classification systems are difficult to support as long-term solutions for encoding problem lists. By design the codes lack granularity to fully describe problems in sufficient detail for clinical use. As a short-term transition use of the classification to link problems to diagnoses used for administrative purposes may offer value to some healthcare providers not yet ready to implement a reference terminology within their health information systems.

SNOMED-CT® is a concept-based nomenclature and reference terminology designed for clinical use in electronic environments. SNOMED CT® requires software applications to fully utilize its benefits .The

terminology offers coded concepts at a level of granularity desirable for expression of a variety of problems and clinical findings requiring further investigation. EHR systems using SNOMED CT® are able to populate a problem list from existing entries in the health record with proper software applications for data management. The CORE Problem List Subset is available from the National Library of Medicine Unified Medical Language System (UMLS).

Sources:

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