



March 15, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Acting Administrator Frizzera,

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-cited solicitation from the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) for comments on the rules related to the **Medicare and Medicaid Programs; Electronic Health Record Incentive Program**. NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as “health centers” or “FQHCs”) throughout the country, and is a 501(c)(3) organization.

BACKGROUND

There are, at present, approximately 1200 FQHCs serving close to 20 million patients nationwide. Most FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS.

Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center’s board of directors must be made up of at least fifty-one percent users of the health center and the health center must offer services to all persons in its area, regardless of his or her ability to pay. BPHC’s grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as to maintain the health center’s infrastructure. Patients from

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eligible communities, who are not indigent and are able to pay or who have insurance (public or private) are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

FQHCs provide comprehensive primary care services and serve as medical homes for the over 20 million patients they serve. As such, FQHCs utilize a team model approach with primary care services provided by physicians, nurse practitioners, nurse midwives, physician assistants and dentists. Most health centers also provide dental services and behavioral health services. Over seventy percent of health centers provide these services on site utilizing behavioral health professionals.

In both the Medicare and Medicaid programs, health centers are reimbursed using an all-inclusive per visit rate for the care they provide to their patients. In Medicaid, this formula is known as a prospective payment system (PPS) and the initial per visit rate is set using the average of the reasonable cost of providing care to a health center's patients, as described in Section 1902(bb) of the Social Security Act. In Medicare, health centers are reimbursed using a per visit cost based reimbursement, subject to an upper payment limit and productivity screens, as noted in Section 1833(a)(3) of the Act. These payments are made **to the FQHC as an entity**, and not to the individual provider, which makes health centers unique in these programs.

COMMENTS ON THE PROPOSED RULE

NACHC appreciates the opportunity to respond to the proposed rule on the Medicare and Medicaid electronic health records incentive program published in the Federal Register on January 13, 2010. We would like to thank CMS for their work on this proposed rule, as health centers nationwide often cite the high cost of these systems as a barrier to adoption and implementation. Health centers often operate on small margins (less than 1 percent), with little room for additional expenses and they must rely on outside funding to secure the funds for adoption and implementation of EHRs. These incentives will help ensure that health centers, and other Medicare and Medicaid providers, adopt and implement these critically important systems.

NACHC would like to provide comments on a number of the Medicaid provisions in the proposed rule, as noted below.

Payments to Eligible Providers

As we read CMS's proposed rule, incentive payments for the adoption of EHR are to be paid by the state Medicaid agency directly to the individual eligible practitioners (EPs) unless the EP has assigned payments over to his or her employer or facility. 42 CFR 495.350, as proposed at 75 Fed Reg 2009. With regard to FQHCs, NACHC believes that it would be appropriate for the state Medicaid agency to make these payments **directly** to the FQHC that employs, or contracts with, the EP on the presumption that the EP would assign payment to the FQHC, unless the EP specifically instructs the State that payment should be made directly to the EP for specific reasons such as the EP maintaining that he has paid for the

EHR technology out of his own funds or that he does not practice predominantly at the FQHC, etc. The reasons for employing such a presumption are several:

1. FQHCs, as a matter of course, pay for the EHR technology and adoption costs that are used by the EPs who are employed by or under contract to the FQHC
2. The patients being treated by these EPs are patients of the FQHC
3. State Medicaid agencies currently pay FQHCs directly (a per visit rate) for the services provided by FQHC employees and contractors to patients of the FQHC. So too do Medicare, and private insurance companies.
4. If an EP receives the payments from the State Medicaid agency, such income might be taxable to the EP under federal and state tax laws, even though the EP would be turning the payment over to the FQHC and receive no financial benefit from such payment.
5. Without such a presumption, the FQHC, its EPs and the State Medicaid agency would have to establish and pursue an administratively burdensome and time-consuming process for establishing an assignment process, possibly requiring revising contracts between the centers and their employees/contractors, etc.

For these reasons, NACHC requests that CMS devise a presumptive assignment process that will allow for relatively seamless payment from state Medicaid agencies to FQHCs unless an EP employed by or under contract to the FQHC specifically objects to such payment on grounds that would justify payment to the EP. Particularly important, we believe such a rule would be most consistent with Congressional intent with regard to the relevant EHR provisions in ARRA which clearly reflect Congress being intent on assuring that FQHCs are able to maximize benefits of CMS EHR funding.

Physician Assistants as Eligible Providers

Proposed rule 42 CFR 495.304(5) defines an EP to include a “physician assistant practicing in a Federally Qualified Health Center or Rural Health Clinic, which is so led by a physician assistant”. 75 Fed Reg 2001. It is unclear whether this rule, as proposed, covers physician assistants practicing predominantly at FQHCs, or only those at FQHCs that are led by physician assistants. NACHC supports the former application of the proposed rule since FQHCs employ substantial numbers of physician assistants and we believe it was Congress’ intent to provide funds to all such physician assistants and not just those in centers that are led by physician assistants. Indeed, it is difficult to believe that Congress intended anything other than such an application of the law since to qualify as an FQHC, a health center must meet the requirements of Section 330 of the Public Health Service Act (42 USC 254b) which requirements make it very difficult for a qualifying center to be led by a physician assistant. In other words, if ARRA law and this proposed rule are read to apply only to physician assistant–led FQHCs, few if any FQHCs would qualify. It is difficult to believe that Congress established criteria for coverage which few physicians’ assistants could meet.

To provide CMS an indication of the effect of a restrictive reading of this proposed rule, NACHC reviewed the most recent Uniform Data Set (UDS) data available from HRSA. That data reflects that health centers currently employ **1700** Full Time Equivalent (FTE) physician assistants working in FQHCs across the nation, many of them in very rural areas where other primary care providers are scarce. These 1700 FTEs work in 655 distinct health centers, over half of all health centers across the country. NACHC's analysis showed that there were only 55 health centers that had at least one FTE physician assistant and less than one FTE physician. Although there is no clear indicator available it would appear that only these 55 instances (8.3% of all physician assistants working in all FQHCs) **might** qualify as meeting the criteria "so led by a physician assistant". The number may be lower since the part-time physician in each of these 55 health centers might still be the clinical leader in that center.

Should CMS determine that only physician assistants at physician assistant-led FQHCs qualify as EPs, NACHC believes that CMS must then apply such criteria on a **site basis** rather than to the entire FQHC entity. While it is unlikely that any FQHC entity with several sites will be led by a physician assistant, it is possible that a number of sites of an FQHC entity are so led, particularly in rural areas. Indeed, we suspect that the 55 centers noted in the prior paragraph are individual sites of FQHCs that operate more than one site. If CMS does not apply the physician assistant –led rule to individual sites, it is possible that fewer than the 55 physician assistants noted above working predominantly at an FQHC will qualify as an EP. Clearly Congress would not have defined as a category of EPs a non-existent group of physician assistants. Consequently, as a minimum it had to be referring to physician assistant-led FQHC sites.

Needy Individual Requirement

In Section 1903(t)(2)(A)(iii) of the Medicaid statute, Congress defines an EP to include one who practices predominantly in a FQHC and has at least 30 percent of his or her patient volume attributable to "needy individuals". Section 1903(t)((3)(F) defines a "needy individual" to include one who is receiving care under the Medicaid or CHIP programs, one who is receiving uncompensated care, or one whose charges are reduced by the provider on a sliding scale based on the individual's ability to pay. It is obvious that these two provisions were legislated by Congress specifically to reflect, accommodate and assure EHR funds going to FQHCs in recognition of the large numbers of Medicaid, CHIP and other "needy individuals" treated by FQHCs. Consequently, it is appropriate and consistent with this Congressional recognition, that proposed rules 42 CFR 495.304(c)(3) and 495.306(a)(1)(ii)(B) be revised to provide that the 30 percent "needy individuals" volume requirement not be applied on a per provider basis but rather be applied to the FQHC entity. Such an approach would also be consistent with how Medicaid payments are made for services provided to patients of an FQHC—which is a per visit amount paid directly to the FQHC. If CMS was to require that each provider at a FQHC be able to document that he or she meets the 30 percent rule, it would be imposing an additional burden on FQHCs and their providers. It could also result in an FQHC having to frequently change provider/patient assignments to assure that each EP could meet the 30 percent requirement, even though the FQHC overall easily exceeds that percentage.

Definition of Full Time Equivalent

Due to the often poor health of the patients served at health centers, and the locations of sites, and the salary scales for FQHC providers, FQHCs often have difficulties in recruiting and retaining full time providers. Consequently, FQHCs often must rely on part time and volunteer providers to ensure the proper staffing to meet the needs of the health center's patients. This strategy has worked for health centers nationwide to deliver the best care possible to their patients.

However, as a health center adopts and implements an EHR they are also responsible for the purchase of licenses, on an FTE basis, with the technical assistance cost assessed by provider. This means that health centers must pay the full cost for technical assistance for these providers, regardless of the number of hours he or she may spend at the health center. NACHC requests more clarity on the issue of part time providers in the final rule. We recommend the following approach for providers who do not practice predominately at an FQHC.

1. For the EP that practices less than predominately at the FQHC, the EP should be given the choice of assigning the incentive payment to the FQHCs. The award for the EP would be proportional to the hours worked at the FQHC. In applying, the FQHC would submit the EP's NPI with their application, thus preventing any duplicate payments.
2. For the EP that practices less than predominately at the FQHC, but who does meet, through a variety of sites, the 30 percent needy individual/Medicaid requirement, the EP be given a choice of assigning the payment to the FQHC and the FQHC would submit the EP's NPI with its application.

Net Average Allowable Costs

Section 1903(t)(3)(E) calculates the "net average allowable cost" by reducing the EHR incentive fund award amount by any payment that is made to the provider from any other source that is directly attributable to payment for certified EHR technology or support services. NACHC's understanding is that any funds an FQHC has received from other sources—such as HRSA Capital Improvement Funds or HRSA Health Center Controlled Network (HCCN) funds—would not be a basis for reducing a center's receipt of EHR-assigned funds from its EPs as proposed in our previous comment. As we proposed in that comment, CMS should instruct the state Medicaid agencies to **presume** assignment to an FQHC of EHR payments from EPs employed or under contract to an FQHC, and to make such payments directly to the FQHC unless the EP informs the state agency otherwise. Under this scenario, the EP is not the FQHC; consequently the funds the center receives through such assignments should not be reduced due to the receipt by the FQHC of other sources of funding for EHR technology. In this same vein, NACHC urges CMS to make clear to state Medicaid agencies that any funding a FQHC may receive per assignment from its EPs or any funds the center may have received through HRSA Capital Improvement Funds **cannot** be the basis for a state reducing its per visit payment to FQHCs required under Section 1902(bb).

First Year Payment for Eligible Providers Who Have Already Adopted, Implemented, or Upgraded

NACHC agrees with CMS in its interpretation of the statute that an “early adopter,” one who has already adopted, implemented and is demonstrating “meaningful use,” is eligible for the first year of payment. In the preamble to these proposed rules, CMS requests comments on an alternative proposal relating to “early adopters,” in which these providers would receive a maximum of \$8,500 per year for the use of this technology. NACHC asks that CMS **not use** this approach for “early adopters” and instead ensure that these providers receive the same maximum payments for the same period of time as eligible providers that begin to adopt, implement, and upgrade in the first year.

As noted by CMS later on in its preamble, the cost of adopting and implementing a new EHR system varies widely, and “early adopters” have already fronted the cost of these expensive systems. Health centers often operate on small margins (less than 1 percent) and rely on every funding source available to undertake such a large expense, such as the purchase of an EHR. The incentive funds will certainly help ease the burden they face purchasing such a system. NACHC estimates that implementing this alternative strategy will negatively impact health centers nationwide, resulting in a loss of over **\$35 million** in potential incentive payments. NACHC recommends that the final rule allow for early adopters to receive the full incentive for meaningful users in the first payment year.

Meaningful Use

The preamble to the proposed rule provides an overview of the various reporting requirements that an eligible provider must meet in order to demonstrate “meaningful use.” NACHC appreciates CMS’ use of a phased-in approach to achieve “meaningful use.” This approach will allow eligible providers ample time to work through the first stage and to work through any difficulties they may encounter, as well as help shape the future stages of meaningful use as appropriate.

Specific to the Medicaid incentives, NACHC appreciates CMS’ requirement that “States seeking to modify or propose alternative demonstration methods must submit the proposed methods for prior CMS approval” (Section II.A.4.a, found at 75 Fed. Reg. 1903). This requirement will ensure that eligible providers participating in the Medicaid program will have ample time to work with their States to meet any additional methods.

NACHC would like to share the following concerns about certain measures included in Stage 1 of “meaningful use.” In future Stages, it is important to ensure that the proper infrastructure be in place, both in the community and also within in the EHR, in order to allow eligible providers to report on these measures.

Health IT Functionality Measures

Objective: 80% of all orders are completed using CPOE

NACHC requests further clarification as to how this will be calculated for orders that are not generated using CPOE? It would seem that a manual system would be needed to track this requirement.

Objective: Provide Patients with Timely Electronic Access to Health Information within 96 hours of the Information Being Available

NACHC requests further clarification regarding this requirement, specifically what mechanism will be used to capture the total requests for this information? To our knowledge, this is not a field that is currently required for the certification of an EHR, so it will be difficult for eligible providers to capture this information. NACHC suggests that ONC amend its certification criteria for EHRs and require this functionality prior to requiring that EPs must report on their ability to meet these criteria. We believe that it is necessary to ensure that eligible providers are not required to establish a separate system to specifically capture this data.

Objective: Incorporate Clinical Lab-test Results as Structured Data

Objective: Generate and Transmit Permissible Prescriptions Electronically

Many measures require communication with the community's lab, pharmacy, or other providers in the community. We appreciate the acknowledgement in the proposed rule that the infrastructure necessary to support these objectives may not be readily available in all parts of the country and the reduction in thresholds for these areas in Stage 1 of "meaningful use." However, NACHC believes there are certain areas where even these lower thresholds may be difficult for providers to meet, during Stage 1 and future stages. This is particularly an issue in rural areas, where other providers may not have the infrastructure or resources to adopt this technology and therefore may not be able to communicate using an EHR. We ask that that this requirement should be further reviewed and clarified to allow for these situations in order to avoid any penalties for the eligible providers for not meeting this requirement. Specifically with regard to the prescription objective, the criteria for meeting this requirement should extend beyond the word "permissible" and include language that "the transmission is able to be received by the pharmacy".

Objective: Perform medication reconciliation at relevant encounters and each transition of care

NACHC believes clarification is necessary regarding this objective and the measures used to determine 80 percent of encounters and transition of care. How will this reconciliation be recorded by the EHR?

Objective: 80% of patients receive a copy of their clinical record within 48 hours of their request

Although NACHC is in agreement with the need to provide this information, there is no requirement in the EHRs to have a tracking mechanism to record fulfillment of the patient request. If the audit trail alone indicating that the summary was printed is not satisfactory proof of providing the summary care record, NACHC suggests that ONC amend its certification criteria

for EHRs and require this functionality prior to requiring that EPs report on their ability to meet these criteria.

Objective: Provide patients with electronic access to clinical information within 96 hours of the provider receiving the data

We agree with the need to provide this access for patients; however, EHRs are not now required to provide portals for patients to have access to this information. This requirement would require FQHCs to establish portals, which requires a high level of sophistication in computer programming and integration. This requirement is unrealistic unless EHRs are required to have this functionality. NACHC recommends that ONC amend its certification criteria for EHRs and require this functionality prior to requiring that EPs must report on their ability to meet this criteria.

Objective: Provide summary of care record for each transition of care and referral.

NACHC seeks further clarification on this objective and measure as well. Does this objective require that the summary be provided in the patient's language? Health centers see patients that speak a wide variety of languages, and we want to ensure that if this is in fact a requirement, that the EHRs are able to produce summaries in the various languages. Currently, we are not aware that they have these capabilities and the cost to a health center to translate each of these summaries would be especially high to meet this objective.

Additionally, we seek clarification on the method in which this information will be recorded and if an EHR audit trail is satisfactory to meet this objective. If the audit trail alone indicating that the summary was printed is not satisfactory proof of providing the summary care record, NACHC recommends that ONC amend its certification criteria for EHRs and require this functionality prior to requiring that EPs must report on their ability to meet this criteria.

Clinical Quality Measures

NACHC applauds CMS' goal of requiring EPs to utilize clinical measures and to report these clinical measures to CMS, or in the case of Medicaid EPs to the States. FQHCs report on clinical measures to HRSA on a yearly basis as part of their Section 330 grant requirements. Through this ongoing monitoring of clinical measures, analyses of interventions to improve quality care, combined with ongoing rapid cycle improvement initiatives, FQHCs have consistently demonstrated that they appropriately manage and improve the quality of care they provide to the patients they serve.

In review of the quality measures proposed in the interim rule we have found that these measures do not match the quality measures that HRSA currently requires FQHCs to report. NACHC would like to work with CMS and HRSA to move forward and harmonize the quality measures by 2013 but requests that until quality measures are harmonized across the federal

government system, FQHCs and the EPs who qualify and assign their Medicaid Incentive payments to the FQHC be allowed to report on the current HRSA measures.

Managing the transition from paper to electronic health records (approximately 900 FQHCs with 8,000 – 10,000 EPs will need to make this transition) and simultaneously being required to establish reporting mechanisms to meet the current HRSA measures and the proposed CMS measures will create an administrative burden that FQHCs will not be able to absorb. Most EHRs do not provide the reporting functionality out of the box and require some third party reporting tool to produce the reports required to meet meaningful use. This requires some level of sophistication at the EP level. Currently (based on the NACHC 2008 Survey of HIT Adoption in FQHCs), 40% of health centers do not have a position of MIS Director or CIO. These centers will most likely not be able to report on two sets of measures.

Reporting at the EP level within an FQHC also carries other administrative burdens. A typical FQHC will provide primary care, OB/GYN and pediatric services as well as other professional services to support their mandate to provide comprehensive care. In the proposed interim rule, EPs who select Primary Care as their specialty would be required to report on 26 measures, OB/GYN - 9 measures, Pediatricians - 9 measures. If we add Psychiatrists - 6 measures, the FQHC that provides the administration for these eligible professionals would need to establish mechanisms to report on a total of fifty (50) measures. If other specialties are working predominantly in the FQHC there may be additional measures. In comparison, hospitals are required to report on 42 measures. The administrative burden on the FQHC is disproportionate.

We believe that reporting on the current HRSA measures meets the intent of the interim rule to move the health care system to a more population management, quality focused, outcomes based paradigm and FQHCs are leaders in these initiatives. Utilizing the current HRSA measures will provide measure for three of the categories of EPs – Primary Care, OB/GYN and Pediatricians (see below).

NACHC recommends that until such time as quality measures are harmonized, providers working predominately in FQHCs be allowed to report on these measures from the FQHC entity level. NACHC also offers its support and resources to work with CMS and with HRSA to assist in this harmonization effort through its Clinical Division, its Quality Center and its relationships with health centers and Primary Care Associations across the country. See the HRSA Quality Measures below.

Clinical Measures for Health Center Grantee Performance Reviews

	Cycle	Measure	Worksheet
1.	Perinatal (Effort)	Percentage of pregnant women, beginning prenatal care by end of first trimester. End note/more information	Perinatal Care Clinical Measure 1: Prenatal Care Detail Sheet

2.	Perinatal (Effort)	Percentage of women, who had a postpartum visit within 42 days after delivery. End note/more information	Perinatal Clinical Measure 2: Postpartum Care Detail Sheet
3.	Perinatal (Effort)	Percentage of newborns, who had a follow-up visit within 14 days of birth. End note/more information	Perinatal Clinical Measure 3: Newborn Followup Detail Sheet
4.	Child (Effort)	Percentage of children 5 through 18 years of age diagnosed with “persistent” asthma, who were prescribed appropriate medications. End note/more information	Child Clinical Measure 4: Asthma Detail Sheet
5.	Adolescent (Effort)	Percentage of adolescents, with both a documented Behavioral Risk Assessment and who had a related counseling visit. End note/more information	Adolescent Clinical Measure 5: Behavior Risk Factors Detail Sheet
6.	Adult (Outcome)	Percentage of adults diagnosed with an abnormal lipid profile, whose levels are under control. End note/more information	Adult Clinical Measure 6: Dyslipidemia Detail Sheet
7.	Adult (Effort)	Percentage of adults with abnormal (a-breast OR b-cervical OR c-colon) cancer screening results, for which referral and/or treatment has been initiated within 30 days of test completion. End note/more information	Adult Clinical Measure 7a: Cancer-Breast Detail Sheet Adult Clinical Measure 7b: Cancer-Cervical Detail Sheet Adult Clinical Measure 7c: Cancer-Colon Detail Sheet
8.	Adult(Outcome)	Percentage of adults diagnosed with hypertension, whose blood pressure is under control. End note/more information	Adult Clinical Measure 8: Hypertension Detail Sheet

Clinical Decision Support

As with quality measures, NACHC applauds CMS’ requirement to include Clinical Decisions Support. However, the FQHC would be required to implement five clinical decision support tools for every individual eligible provider specialty that works predominantly in the FQHC. In the scenario provided above the FQHC would have to implement 20 clinical decision support rules. NACHC recommends that FQHCs be allowed to implement 5 clinical support rules across the FQHC eligible providers.

Alternative Methods of Reporting

NACHC recommends that CMS allow as much flexibility in reporting as possible, and that it support the use of new and innovative strategies in reporting. NACHC is developing a “Comprehensive HIT Strategy” to assist health centers and their EPs nationwide in the various reporting requirements. Additionally, Health Center Controlled Networks (HCCNs) and State and Regional Primary Care Associations (PCAs) also serve as a resource for health centers in these areas. HCCNs are HRSA

supported networks controlled and operated by health centers to provide support to health centers in the areas of management, financial, technology and clinical support, and PCAs, are state associations representing health centers. Often, these entities can help health centers in their states or communities best meet their needs, and can provide assistance in reporting to health centers.

We appreciate the opportunity to comment on these proposed regulations and would welcome the opportunity to further discuss these concerns. If you have questions please contact Roger Schwartz or Susan Sumrell at 202.296.3800 or Michael Lardiere at 301.347.0400.

Respectfully Submitted,

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