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March 15, 2010

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: File Code CMS-0033-P (Comments on Proposed Rule for Medicare and Medicaid Programs Electronic Health Record Incentive Program, Federal Register Vol. 75, No. 8, p. 1844)

Dear Ms. Frizzera:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to comment on the proposed rule implementing the provisions of the American Recovery and Reinvestment Act that authorize incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use certified electronic health record (EHR) technology, as published in the January 13, 2010 Federal Register (Vol. 75, No. 8, p. 1844).

On behalf of NRHI's two dozen members – multi-stakeholder Regional Health Improvement Collaboratives working statewide or in a metropolitan region to improve the quality of healthcare services while controlling costs – we have the following comments and recommendations:

- Section II.A.2.c (p. 1852). We support a phased approach to meaningful use requirements, but urge that Stage 2 and Stage 3 requirements be more explicitly designed to support state and regional quality reporting and improvement initiatives, particularly those organized by multi-stakeholder Regional Health Improvement Collaboratives.
- Section II.A.2.d.(1) and Section II.A.2.d.(2) (pp. 1856 and 1863). We recommend that CMS require EPs and eligible hospitals to report clinical quality measures to quality measurement and reporting programs established by Regional

Health Improvement Collaboratives where such programs exist, in addition to reporting the measures to CMS and states.

- Section II.A.2.d.(1) and Section II.A.2.d.(2) (pp. 1855 and 1863). We recommend that in communities where a Regional Health Improvement Collaborative has established a quality improvement program related to the clinical quality metrics required under the regulations, that EPs and eligible hospitals be required to implement any clinical decision support rules that are being used as part of such a program.
- Section II.A.2.d.(1) and Section II.A.2.d.(2) (pp. 1857 and 1864). We recommend that not only should hospitals be required to respond to patient requests for discharge instructions, they should be explicitly required to give patients the opportunity to make requests for electronic copies of discharge instructions and procedures. In addition, we recommend that patients also be given the opportunity to request copies for their primary care physician, and that a higher standard of performance on this measure be required than proposed by CMS.
- Section II.A.3.b, Section II.A.3.h, Section II.A.3.i, and Section III.A.4.b (pp. 1870-1872 and 1901-1903). We recommend that for 2011, instead of requiring only attestation, CMS should require EPs and/or eligible hospitals to electronically report data to those Regional Health Improvement Collaboratives which have the capability to accept electronic reporting of clinical quality data.
- Section II.A.3.b (p. 1871). We support CMS's proposed requirement that EPs and eligible hospitals report clinical quality measures for all patients, not just Medicare and Medicaid patients.
- Sections II.A.3.c-g (pp. 1872-1901). When considering clinical quality measures that are not NQF-endorsed, we recommend that CMS give preference to measures that have been developed and are being successfully used by Regional Health Improvement Collaboratives.
- Sections II.A.3.c-g (pp. 1872-1901). We recommend adding patient-centered composite quality measures to the individual measures identified, and if the list of measures for Stage 1 is to be narrowed from what is proposed, we recommend that outcome measures be selected instead of process measures and that patient-centered composite measures should be used instead of individual measures.

More details on these recommendations are provided below. Amendments to Sections 495.4, 495.6, and 495.8 of the proposed rule that would implement many of the recommendations are detailed in the attachment to this letter.

Why CMS Should Support Regional Quality Measurement, Reporting, and Improvement Initiatives

A number of states and metropolitan regions across the country have formed multi-stakeholder Regional Health Improvement Collaboratives to improve the quality of healthcare services while controlling skyrocketing costs. These Collaboratives have

brought together the healthcare providers and other stakeholders who need to be engaged in HIT implementation: clinicians, hospitals, patients and families, employers, and health plans. With the participation and support of these stakeholders, Regional Health Improvement Collaboratives have designed and implemented statewide or regional programs ranging from public reports on the quality and cost of physicians, hospitals, health plans, and other healthcare providers, to projects that reduce hospital readmissions and improve the health of people with chronic diseases. Two dozen of these Collaboratives have been designated as Chartered Value Exchanges (CVEs) by HHS, and fifteen are being supported by the Robert Wood Johnson Foundation through its Aligning Forces for Quality program. The leading Regional Health Improvement Collaboratives in the country are members of the Network for Regional Healthcare Improvement, which provides a mechanism for Collaboratives to share best practices among themselves. These Collaboratives are:

- Aligning Forces for Quality - South Central Pennsylvania
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Health Insight - Nevada Partnership for Value-Driven Healthcare
- Health Insight - Utah Partnership for Value-Driven Healthcare
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement
- Integrated Healthcare Association
- Iowa Healthcare Collaborative
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Minnesota Community Measurement
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P² Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance
- Quality Counts!
- Quality Quest for Health of Illinois
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange



Regional Health Improvement Collaboratives in the Network for Regional Healthcare Improvement (NRHI)

Many of these Regional Health Improvement Collaboratives are already collecting and publicly reporting an extensive array of quality measures and using them to encourage improvements in the quality of healthcare in their communities. Although most of these programs currently rely on data derived from commercial health plan claims because of the difficulty of obtaining clinical data from providers who do not have electronic health record systems, several Collaboratives, including the Wisconsin Collaborative for Healthcare Quality, Minnesota Community Measurement, and the Health Improvement Collaborative of Greater Cincinnati, have pioneered the use of clinical data to measure quality. They are actively collecting such data from providers, including providers without EHR capabilities, and reporting it to the public. We urge that CMS draw on the experience and expertise of these Regional Health Improvement Collaboratives in defining the specific methods by which eligible professionals are required to submit quality data to CMS.

In addition, we believe that in regions where Regional Health Improvement Collaboratives have already established quality measurement and reporting programs and/or quality improvement goals and initiatives, it is important that the CMS definition of meaningful use supports those programs, goals, and initiatives. There are two reasons for this.

First, the practical reality is that healthcare providers can only implement a limited number of quality measurement and improvement initiatives while still keeping up with patient care responsibilities, so inconsistencies or conflicts between national and regional requirements may force providers to shift resources and attention away from an important local quality improvement initiative they have worked hard to develop in order to comply with the national definition of meaningful use, even though the local initiative could serve equally well to demonstrate meaningful use while achieving greater impacts on the ultimate goal of improved healthcare quality and lower costs.

In fact, the American Recovery and Reinvestment Act supports the importance of coordinating CMS requirements with existing quality measurement and reporting programs. Sections 1848(o)(2)(B)(iii) and 1886(n)(3)(B)(iii) both state “In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required.” However, in the proposed rule (p. 1902), CMS is interpreting this requirement narrowly to refer only to other CMS programs. We believe that this provision should be interpreted more broadly, and that CMS should also seek to avoid redundant or duplicative reporting with state and regional quality measurement and reporting efforts.

Second, the use of electronic health records is not an end in itself, but a means to an end, namely, improving the quality and cost-effectiveness of health care delivery. The keys to quality improvement are (1) having healthcare providers measure their performance, (2) enabling healthcare providers to compare their performance to others, and (3) providing assistance to under-performing providers so that they can improve. The CMS meaningful use requirements will encourage the first of these elements, but the requirements do nothing to encourage or support the other two. Consequently, the

quality measurement, quality reporting, and quality improvement initiatives of Regional Health Improvement Collaboratives are needed to complement CMS's meaningful use requirements and payment incentives in order to ensure that the true goals of ARRA and the HITECH Act are achieved.

How CMS Can Support Regional Quality Measurement, Reporting, and Improvement Initiatives Through Meaningful Use Regulations

We recommend that CMS structure the meaningful use regulations to support and coordinate with Regional Health Improvement Collaboratives in the following ways:

1. Require Reporting of Clinical Quality Measures to Regional Health Improvement Collaboratives

One of the biggest challenges that many Regional Health Improvement Collaboratives face is gaining access to the data needed for measurement and public reporting of data on the quality of healthcare. Although some Collaboratives have access to data required by state laws, the data that CMS is requiring from EPs and eligible hospitals would help most Collaboratives dramatically expand existing quality measurement and reporting programs or accelerate implementation of programs that are in the planning phases. Consequently, we strongly recommend that CMS require EPs and eligible hospitals to report clinical quality measures to quality measurement and reporting programs established by Regional Health Improvement Collaboratives where such programs exist, in addition to reporting the measures to CMS and states.

As noted earlier, several Regional Health Improvement Collaboratives already have the capability of accepting clinical quality data electronically from physicians. In these communities, providers could more easily comply with meaningful use requirements by using their EHRs to submit data to the existing quality measurement portals, as they do now, rather than completing a separate attestation process. In Section III.4.b (page 1903) of the proposed rule, you indicate CMS's interest in testing options for direct electronic reporting of measures. Although you state that you are not proposing to require that any provider be required to participate in such testing, we believe that regional quality reporting programs that have been proven to work should be used where they exist, both to support public reporting and quality improvement in those communities and also to serve as a testing opportunity for CMS. Consequently, we recommend that where a Regional Health Improvement Collaborative exists and has the capability to accept electronic submission of quality information, EPs and eligible hospitals should be required, or at the very least be given the option, to comply with the meaningful use requirements through submission of the data to the Regional Health Improvement Collaborative rather than through a separate attestation process.

We would also note that we support CMS's proposed requirement that EPs and eligible hospitals report clinical quality measures for *all patients*, not just Medicare and Medicaid patients. Regional Health Improvement Collaboratives have clearly demonstrated the importance of having all-payer data for quality measurement and quality improvement purposes; indeed, the difficulty of obtaining Medicare claims data

has been one of the biggest challenges facing those quality measurement programs that rely on claims data, and the Collaboratives that are using clinical data submissions are already obtaining quality measures on all patients.

2. Require That EHRs Be Used to Support Regional Quality Improvement Initiatives

In the proposed rule, CMS is proposing to require that EPs and eligible hospitals implement five clinical decision support rules “relevant to the clinical quality metrics” that are being required. In a number of communities, Regional Health Improvement Collaboratives have developed clinical decision support guidelines and rules and/or are utilizing such guidelines/rules to improve the quality and efficiency of care in their communities. Rather than merely requiring EPs and eligible hospitals to use *any* relevant decision support rules and allowing different EPs and hospitals in the same community to use *different* rules, we would strongly recommend that in communities where a Regional Health Improvement Collaborative has established a quality improvement program related to the clinical quality metrics, CMS should require EPs and eligible hospitals to implement the clinical decision support rules that are being used as part of that program.

3. Use Quality Measures That Have Been Tested and Implemented by Regional Health Improvement Collaboratives

We support CMS’s policy of giving preference to the use of NQF-endorsed measures for quality measurement, but not restricting itself to those measures, since there are many important aspects of healthcare performance where no measures have received such endorsement.

However, we would urge that in selecting non-NQF endorsed measures to add to the list of measures required to demonstrate meaningful use, CMS should first look to measures that have been successfully implemented by Regional Health Improvement Collaboratives. Several Collaboratives have developed and are successfully using quality measures that have not yet been endorsed by NQF or which improve on NQF-endorsed measures in important ways based on experience in actually implementing them. For example:

- Minnesota Community Measurement is using a measure of the remission rate from depression in conjunction with a major, successful community initiative to improve the treatment of individuals with depression.
- Quality Quest for Health of Illinois uses a composite measure of quality for colonoscopies, and is currently pilot-testing a composite measure of whether all appropriate preventive care has been performed.
- The Wisconsin Collaborative for Healthcare Quality uses two composite measures to measure optimal care and control for patients with diabetes.

Not only would the experience of these Regional Health Improvement Collaboratives be helpful to CMS in selecting measures that can be successfully

implemented, it would be helpful to the Collaboratives if CMS would reinforce the use of those existing measures, whereas it would be counterproductive if CMS requires the use of conflicting measures. Consequently, when considering clinical quality measures that are not NQF-endorsed, we recommend that CMS give preference to measures that have been developed and are being successfully used by Regional Health Improvement Collaboratives. In particular, we would recommend use of composite quality measures, as described in more detail below.

4. Use of EHRs to Support Programs to Create Medical Homes and Accountable Care Organizations and to Reduce Readmissions

A number of Regional Health Improvement Collaboratives are actively engaged in initiatives to help primary care practices develop the capabilities needed to serve as a Patient-Centered Medical Home or Accountable Care Organization (ACO). One of the most important outcomes that medical homes and ACOs can achieve is to reduce preventable hospital readmissions for patients with chronic disease, since these are both bad for patients and expensive for Medicare and other payers. Yet one of the biggest challenges for primary care practices in reducing these readmissions is finding out when hospitalizations and discharges occur and getting accurate and timely information on the treatment delivered in the hospital and the follow-up care needed.

Consequently, in addition to the proposed requirement that patients be given an electronic version of their discharge instructions and procedures at the time of discharge if they request it, we would recommend that (1) hospitals be required to give patients the opportunity to make the request, (2) patients also be given the opportunity to request that the information be provided to their primary care practice, and (3) the standard for successful delivery of this information be higher than 80%. We would propose that hospitals be required to show that at least 90% of patients were given the opportunity to make this request, and that 90% of the requests made were fulfilled. The product of these two percentages is approximately the same as the nominal 80% requirement in the proposed rule, but the improvement in outcomes for patients is likely to be much greater.

5. Coordination with NRHI and Regional Health Improvement Collaboratives in Developing Stage 2 and Stage 3 Meaningful Use Requirements

We support a phased approach to meaningful use requirements, but we urge that Stage 2 and Stage 3 requirements be more explicitly designed to support state and regional quality reporting and improvement initiatives, particularly those organized by multi-stakeholder Regional Health Improvement Collaboratives. NRHI and its members would be pleased to work with CMS to develop these requirements so that they can be successfully implemented and achieve the maximum impact on healthcare quality and value.

Use of Outcome Measures and Composite Quality Measures

Ideally, quality measurement should be focused primarily on outcomes. Although process measures are useful, in many cases, it is more important to know the outcome of the process (e.g., whether a patient's blood pressure is under control) than merely whether steps in the process were carried out (e.g., whether the patient's blood pressure was checked). A major barrier to outcome measurement today is that many quality measures are based on claims data, which primarily measure processes, not outcomes. The real value of EHR-driven quality measures is the opportunity to expand the number of outcome-based measures. Consequently, we would urge CMS to give priority to outcome measures, including intermediate outcomes, when it is choosing measures to require for demonstration of meaningful use.

A problem with both process and outcome measures is that in many cases, individual physicians have too few patients for which the measure is applicable to allow statistically valid measurement. An important way of increasing the size of the denominator and the consequent reliability of the measure is to use patient-centered composite measures, e.g., a measure of whether "all preventive care is up to date," rather than separate measures of whether individual items such as smoking cessation counseling, mammography, etc. have been carried out.

Patient-centered composite measures also have the advantage of setting a higher quality bar for performance and simplifying the number of measures that physicians and consumers need to monitor. For example, rather than separately tracking three different aspects of diabetes care – blood sugar, lipids, and blood pressure – a single composite measure assures that all of the clinical targets needed for good care outcomes are met.

Consequently, we recommend adding patient-centered composite quality measures, such as those being used by Quality Quest for Health of Illinois and the Wisconsin Collaborative for Healthcare Quality, to the individual measures identified in Table 3, or replacing some of the existing measures in Table 3 with patient-centered composite measures.

Having an explicit policy of prioritizing outcome measures and patient-centered composite measures is particularly important because on page 1891 of the proposed rule, you indicate that you "expect to narrow down each proposed set [of measures] to a required subset of 3 to 5 measures based on the availability of electronic measure specifications and comments received." If the list of measures is to be narrowed, rather than choosing one measure from several equally important measures, such as for diabetes, we recommend that a single patient-centered composite measure be used instead.

We appreciate the opportunity to provide these comments, and we would be happy to answer any questions or provide any additional information that you would find helpful. Please feel free to contact me if we can be of assistance as you finalize these important regulations.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Miller". The signature is fluid and cursive, with a large initial "H" and a long, sweeping underline.

Harold D. Miller
President and CEO

cc: NRHI Members
David Blumenthal, National Coordinator for Health Information Technology

Attachment: Proposed amendments to Part 495 – Standards for the Electronic Health Record Technology Incentive Program

RECOMMENDED AMENDMENTS TO PROPOSED REGULATIONS
FOR PART 495 – STANDARDS FOR THE ELECTRONIC HEALTH
RECORD TECHNOLOGY INCENTIVE PROGRAM

§ 495.4 Definitions.

State or Regional Multi-Stakeholder Quality Improvement Program means a program operated by a governmental or non-profit agency with the active involvement of healthcare providers, patients, employers, and payers (such as commercial health plans and self-funded employer health plans) to assist physicians, hospitals, or other healthcare providers to improve their performance in delivering quality health care services. This includes organizations designated as Chartered Value Exchanges by the Department and Regional Health Improvement Collaboratives which are members of the Network for Regional Healthcare Improvement.

State or Regional Multi-Stakeholder Quality Measurement Program means a program operated by a governmental or non-profit agency with the active involvement of healthcare providers, patients, employers, and payers (such as commercial health plans and self-funded employer health plans) to measure the quality of care delivered by physicians, hospitals, or other healthcare providers, compare their performance, and report to the public on providers' performance. This includes organizations designated as Chartered Value Exchanges by the Department and Regional Health Improvement Collaboratives which are members of the Network for Regional Healthcare Improvement.

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

(c) *Stage 1 criteria for EPs and eligible hospitals or CAHs.*

(10)(i) *Objective.* Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic testing, along with the ability to track compliance with those rules.

(ii) *Measure.* Where a state or regional multi-stakeholder quality measurement or quality improvement program exists and has developed clinical decision support rules or guidelines relevant to the clinical quality metrics reported under this subpart, implement the clinical decision support rules developed as part of that program; otherwise, implement any five clinical decision support rules relevant to the clinical quality metrics reported under this subpart.

(d) *Additional Stage 1 criteria for EPs.*

(3)(i) *Objective.* Report ambulatory quality measures to CMS or, in the case of Medicaid EPs, the States, and where a state or regional multi-stakeholder physician quality measurement program exists, report ambulatory quality measures to that program.

(ii) *Measure.* Successfully report to CMS (or in the case of Medicaid EPs, the States) clinical quality measures in the form and manner specified by CMS and, if a state or regional multi-stakeholder physician quality measurement program exists, receive certification from that program that relevant clinical quality measures have been successfully reported to it.

(e) *Additional Stage 1 criteria for eligible hospitals or CAHs.*

(2)(i) *Objective.* Report hospital quality measures to CMS or, in the case of Medicaid eligible hospitals, the States, and where a state or regional multi-stakeholder hospital quality measurement program exists, report hospital quality measures to that program.

(ii) *Measure.* Successfully report to CMS (or in the case of Medicaid eligible hospitals, the States) clinical quality measures in the form and manner specified by CMS and, if a state or regional multi-stakeholder hospital quality measurement program exists, receive certification from that program that relevant clinical quality measures have been successfully reported to it.

(4)(i) *Objective.* Provide patients and their primary care physicians with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.

(ii) *Measure.* At least ~~89~~90 percent of all patients who are discharged from an eligible hospital or CAH ~~and who are given the opportunity to request an electronic copy of their discharge instructions and procedures for themselves and for their primary care physician, and the electronic copy is provided to the designated parties in at least 90% of the cases in which it is requested~~ are provided it.

§ 495.8 Demonstration of meaningful use criteria.

(a) *Demonstration by EPs.* An EP must demonstrate that he or she satisfies each of the applicable objectives and associated measures under § 495.6 of this subpart as follows:

(1) For CY 2011,

(i) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State), that during the EHR reporting period, the EP used certified EHR technology, and specify the technology used.

(ii) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State), that during the EHR reporting period, the EP satisfied each of the applicable objectives and associated measures under § 495.6 of this part, except § 495.6(d)(3). The EP must specify the EHR reporting period and provide the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable.

(iii) If a state or regional multi-stakeholder physician quality measurement program exists in the community where the provider is located and has the capability to accept electronic submissions of clinical quality measures, report electronically to that program the measures required under § 495.6(d)(3). If no such program exists or the program cannot accept electronic submissions of measures, then the EP should attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State), that during the EHR reporting period, the EP met the requirements of § 495.6(d)(3).

~~(iii)~~ (iv) For Medicaid EPs, if, in accordance with § 495.316 and § 495.332, CMS has approved a State's additional criteria for meaningful use, demonstrate meeting such criteria using the method approved by CMS.

~~(iv)~~ (v) *Exception for Medicaid EPs.* If a Medicaid EP has adopted, implemented or upgraded certified EHR technology described in § 495.4

of this subpart, the provider must demonstrate meaningful use in the second payment year as described in § 495.6 and § 495.8 of this subpart.

(2) For CY 2012 and subsequent years—

(i) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State) that during the EHR reporting period, the EP used certified EHR technology and specify the technology used.

(ii) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid EP, in a manner specified by the State), that during the EHR reporting period, the EP satisfied each of the applicable objectives and associated measures under § 495.6, except § 495.6(d)(3) “Report ambulatory quality measures to CMS or, in the case of Medicaid EPs, the states.”

(iii) For § 495.6(d)(3), “Report ambulatory quality measures to CMS or, in the case of Medicaid EPs, the States”, report electronically to CMS (or in the case of Medicaid EPs, the States) clinical quality information in the form and manner specified by CMS, and where a state or regional multi-stakeholder physician quality measurement program exists, report ambulatory quality measures to that program.

(iv) For Medicaid EPs, if, in accordance with § 495.316 and § 495.332, CMS has approved a State’s additional criteria for meaningful use, demonstrate meeting such criteria using the method approved by CMS.

(b) *Demonstration by eligible hospitals and CAHs.* To successfully demonstrate meaningful use an eligible hospital or CAH must the [sic] following requirements:

(1) For FY 2011—

(i) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital or CAH used certified EHR and specify the technology used.

(ii) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital or CAH satisfied each of the applicable objectives and associated measures under § 495.6, except § 495.6(e)(2). The eligible hospital or CAH must specify the EHR reporting period and provide the result of each applicable measure for all

patients admitted to the eligible hospital during the EHR reporting period for which a selected measure is applicable.

(iii) If a state or regional multi-stakeholder hospital quality measurement program exists in the community where the eligible hospital is located and has the capability to accept electronic submissions of clinical quality measures, report electronically to that program the measures required under § 495.6(e)(2). If no such quality measurement program exists or the program cannot accept electronic submissions of measures, then the eligible hospital should attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital met the requirements of § 495.6(e)(2).

~~(iii)~~ (iv) *Exception for Medicaid eligible hospitals.* If a Medicaid eligible hospital has adopted, implemented or upgraded certified EHR technology for the first payment year, the eligible hospital must demonstrate meaningful use in the second payment year, see § 495.6 and § 495.8.

~~(iv)~~ (v) For hospitals participating in the Medicaid EHR incentive program, if, in accordance with § 495.316 and § 495.332, CMS has approved a State's additional criteria for meaningful use, demonstrate meeting such criteria using the method approved by CMS.

(2) For FY 2012 and subsequent years must—

(i) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital or CAH used certified EHR and specify the technology used.

(ii) Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid eligible hospital, in a manner specified by the State), that during the EHR reporting period, the eligible hospital or CAH satisfied each of the applicable objectives and associated measures under § 495.6 except § 495.6(e)(2). The eligible hospital or CAH must specify the EHR reporting period and provide the result of each applicable measure, except for § 495.6(e)(2) "Report hospital quality measures to CMS or, in the case of Medicaid eligible hospitals, the States:"

(iii) For § 495.6(e)(2) "Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States," report electronically to CMS (or in the case of Medicaid eligible hospitals, the States), clinical quality measures in the form and manner specified by CMS, and where a state or regional multi-stakeholder hospital quality measurement program exists, report clinical quality measures to that program.

(iv) For Medicaid hospitals if, in accordance with § 495.316 and § 495.332, CMS has approved a State's additional criteria for meaningful use, demonstrate meeting such criteria using the method approved by CMS.

(c) *Review of meaningful use.* (1) CMS may review an EP, eligible hospital or CAH's demonstration of meaningful use.

(2) EPs, eligible hospitals, and CAHs must keep documentation supporting their demonstration of meaningful use for 10 years.