December 4, 2009

Nancy-Ann DeParle
Director
White House Office of Health Reform
725 17th St., NW
Washington, DC 20503

Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Tony Trenkle
Director
Office of e-Health Standards and Services
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Dear Ms. DeParle, Ms. Sebelius, and Mr. Trenkle,

As the Centers for Medicare & Medicaid Services (CMS) drafts regulations to implement the health information technology (HIT) provisions of the *American Recovery and Reinvestment Act* (ARRA), we would like to comment on two aspects of the law. We appreciate that we will have a formal opportunity to comment on these issues through the regulatory process, but feel it is important to highlight them now, as they could create barriers to and prevent the widespread adoption of HIT. Bearing in mind that the purpose of ARRA is to encourage the adoption and use of electronic health records, we would like to comment on the definition of a hospital and the definition of a hospital-based physician, both of which are key to ensuring that incentives are available to the greatest number of hospitals and physicians.

DEFINITION OF A HOSPITAL

The payment incentives in ARRA are available to each hospital that is a meaningful user of a certified electronic health record (EHR) and ARRA defines "hospital" as a subsection (d) hospital. While on the face of it, it may seem simplest to use existing hospital identifiers, such as Medicare provider numbers or National Provider Identifiers (NPIs), to define a hospital, we caution against doing so as the only means of identifying a hospital. A number of health systems have one Medicare provider number for multiple hospitals. Obtaining an individual provider number for each individual hospital would be time and cost-prohibitive, and in some cases may not be possible because of state laws. In addition, there is no standard approach to exactly what facilities a Medicare provider number or NPI encompasses. Provider numbers can encompass multiple hospital

campuses, for example, while NPIs can conceivably encompass only one department of one hospital. Because the Medicare and Medicaid payment incentives in ARRA are based on a base amount per hospital of $2 million plus a capped per-discharge amount per hospital, using these identifiers could result in the ARRA incentives being distributed in an inappropriate manner.

Further, if the Medicare provider number is used to define a hospital, a health care system with multiple hospital campuses, but a single Medicare provider number, would receive one ARRA incentive payment for the entire health care system (that is, one $2 million base payment plus the capped per-discharge amount). How a hospital is enumerated for purposes of reporting to Medicare should neither disadvantage nor advantage it relative to nearby competing hospitals. The cost of EHR implementation at each site far exceeds the purchase cost of the actual application or software and each site is at least, in part, an autonomous unit, with local systems and policies that must be reflected independently in an EHR implementation. For example, site installations must accommodate different network infrastructures of legacy systems, physician preferences, clinical protocols, expert rules systems, workflows, and ancillary system integration. One campus may be a children's hospital while another may be an adult acute care hospital, each requiring different interfaces and clinical systems. Further, hospitals incur additional administrative system costs for necessities such as workstation installation, servers, and staff training, and differences in clinical services between sites may require additional unique variations between facilities.

We recommend that, for purposes of the ARRA HIT incentives, CMS define a hospital as a discrete site of service, so that individual sites of multi-campus facilities are eligible to qualify separately for the incentives. CMS has avenues through which it could collect data by individual campuses, which would be consistent with the statute.

DEFINITION OF A HOSPITAL-BASED PHYSICIAN

The HIT incentive payments in ARRA are also available to qualifying physicians. However, since separate hospital incentives are available, ARRA excludes hospital-based physicians from receiving incentives. The law defines hospital-based physicians as those individuals who furnish substantially all of their services in a hospital setting using the facilities and equipment, including the EHR, of the hospital. We are concerned that broad regulatory interpretation of this hospital-based physician definition may inappropriately exclude physicians practicing in outpatient centers and provider-based clinics merely because their office or clinic is located in a facility owned by the hospital.

An EHR in a hospital ambulatory setting is an entirely different module from an EHR in a hospital inpatient setting because of the inherent differences between the types of care provided in each. In fact, many physicians who treat patients in the ambulatory setting do not provide care in the inpatient setting, and thus, do not use the inpatient EHR. Accordingly, implementing an EHR in an ambulatory setting requires a significant cost separate from the cost of the inpatient EHR. Physicians may contribute financially to the ambulatory EHR, meaning that they are not furnishing substantially all of their services using the facilities and equipment, including the EHR, of the hospital.

Although the inpatient and ambulatory EHR modules are distinct, they also must be interoperable. Because many inpatients are treated by the same hospital in an ambulatory setting, they are greatly benefitted by this interoperability. For example, interoperable EHRs allow physicians to more closely monitor and track chronic care patients, and easily send patient reminders with respect to appointments and prescriptions, thereby improving quality, increasing efficiency, and providing better preventative care.

We thank you for your consideration in these matters.

Sincerely,

Cambridge Health Alliance
Medford, Massachusetts

Catholic Health
Buffalo, New York

Catholic Health East
Newton Square, Pennsylvania

Cedars-Sinai Health System
Los Angeles, California

Christiana Care Health System
Wilmington, Delaware

Cleveland Clinic
Cleveland, Ohio

Community Health Systems
Franklin, Tennessee

Geisinger Health System
Danville, Pennsylvania

Hospital Corporation of America
Nashville, Tennessee

Hospital Sisters Health System
Springfield, Illinois

Intermountain Healthcare
Salt Lake City, Utah

Kaleida Health
Buffalo, New York

Lourdes Health System
Camden, New Jersey

Loyola University Health System
Maywood, Illinois

Massena Memorial Hospital
Massena, New York

Memorial Hermann Healthcare System
Houston, Texas

Mercy Fitzgerald Hospital
Darby, Pennsylvania

Mercy Health System
Conshohocken, Pennsylvania

Mercy Health System of Maine
Portland, Maine

Mercy Philadelphia Hospital
Philadelphia, Pennsylvania

Mercy Suburban Hospital
East Norriton, Pennsylvania

Montefiore Medical Center
Bronx, New York

The Mount Sinai Medical Center
New York, New York

Nazareth Hospital
Philadelphia, Pennsylvania

Nemaha County Hospital
Auburn, Nebraska

New York University Langone Medical Center
New York, New York

NorthShore University Health System
Evanston, Illinois

Ochsner Health System
New Orleans, Louisiana

Oregon Health and Science University Healthcare
Portland, Oregon

St. Francis Hospital
Wilmington, Delaware

St. Francis Medical Center
Trenton, New Jersey

St. James Mercy Health System
Hornell, New York

St. Luke's Health System
Kansas City, Missouri

St. Mary's Health Care System
Athens, Georgia

Sinai Health System
Chicago, Illinois

Stanford Hospital and Clinics
Stanford, California

Sutter Health
Sacramento, California

Tenet Healthcare Corporation
Dallas, Texas

University Hospitals
Cleveland, Ohio

The University of Kansas Hospital
Kansas City, Kansas

Vanguard Health Systems
Nashville, Tennessee

Virtua
Marlton, New Jersey

Wake Forest University Baptist Medical Center
Winston-Salem, North Carolina

cc: Dr. David Blumenthal, National Coordinator for Health Information Technology
Ms. Charlene Frizzera, Acting Administrator, Centers for Medicare & Medicaid Services