HELP HOSPITALS GET NEEDED HEALTH IT FUNDING

Deadline: Friday, March 5th COB

Dear Colleague:

In February, 2009, legislation passed by Congress contained provisions to stimulate the adoption of health information technology. Specifically, the legislation provided for Medicare and Medicaid payment incentives for hospitals who are "meaningful users" of certified electronic health records (EHRs) by dates set forth in the law.

The definition of what constitutes meaningful use was left to the Centers for Medicare and Medicaid Services (CMS) to promulgate by regulation; CMS published a rule in the Federal Register on January 13, 2010. Hospitals who fail to become meaningful users by 2015 are subject to significant payment penalties.

In the rule, hospitals are required to capture and communicate electronically a specific number of EHR and clinical quality measures in each of 3 years—Fiscal Years (FY) 2011, 2013, and 2015. We are hearing from our hospitals that the time frames set by the rule are unrealistic and that the number of the EHR and quality objectives specified—particularly for FY 2011--will be extremely difficult for many hospitals to meet.

Congress intended that the payment incentives for the adoption of EHRs would reward early adopters and provide realistic goals for all others to try to reach. Please join us in signing the attached letter to Acting CMS Administrator Charlene Frizzera, urging her to adopt changes to the proposed definitions that would create a more reasonable avenue to help hospitals become "meaningful users" of certified EHR technology.

For questions or to sign on, please contact Dan Farmer with Rep. Space (dan.farmer@mail.house.gov), J.P. Paluskiewicz with Rep. Burgess (james.paluskiewicz@mail.house.gov), Emily Gibbons with Rep. Engel (emily.gibbons@mail.house.gov), or Thomas Power with Rep. Stearns (thomas.power@mail.house.gov).

Sincerely,

/s/	/s/	/s/	/s/
ZACK SPACE	MICHAEL BURGESS	ELIOT ENGEL	CLIFF STEARNS
Member of Congress	Member of Congress	Member of Congress	Member of Congres

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Ms. Frizzera,

We are writing to urge you to modify your proposed definition of and requirements for hospitals to become qualified as "meaningful users" of certified electronic health record (EHR) technology. The Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding Medicare and Medicaid incentives for meaningful use of EHRs is, we fear, too much too soon for the vast majority of America's hospitals and does not take into account the progress hospitals already have made toward the goal of universal EHR adoption. Furthermore, the regulation's narrow definition of an eligible provider would preclude individual campuses of multi-campus hospitals and many physicians that CMS considers "hospital-based" from even participating in the incentive program. The proposed rule would essentially prohibit physicians providing primary care services in hospitals clinics from being eligible for the incentive program. It is our belief that it would likely result in a majority of hospitals, particularly rural and safety-net providers, being financially penalized for an inability to comply.

Meaningful Use Definition

The EHR rule goes against the intent of Congress to reward those hospitals that already have taken important steps toward implementing EHR systems and to provide incentives to encourage further development. It proposes an ambitious all-or-nothing approach in which hospitals would be required to adopt all 23 separate EHR objectives, or requirements, that very few hospitals have yet been able to accomplish. The rule should be altered to recognize a practical, staged approach to EHR adoption that rewards the efforts already underway in America's hospitals.

We strongly urge you to modify the meaningful use requirements in the rule so that it:

- Requires a narrow base of objectives in 2011 to qualify as a meaningful user of EHRs and increases the requirements over time until all required objectives are operational by 2017;

- Extends the transition to 2017 so that it mirrors the transition established for Medicare payment penalties for non-meaningful users of EHRs;
- Grandfathers certification requirements for existing systems in use for 24 months to ensure that the current delay in HHS's development of a certification process and time needed to become certified does not prevent a hospital from being considered a meaningful user;
- Includes quality reporting of measures that have been fully tested and validated for EHR reporting and for which CMS has an ability to accept in EHR form; and
- Excludes non-clinical objectives such as electronic insurance verification and claims submission that are unrelated to patient care and rely on voluntary payer participation.

Additionally, states should not be allowed to make it harder to qualify for Medicaid EHR incentive payments. The Medicaid incentives should also be considered separate and apart from other Medicaid program payments for services. Further, Critical Access Hospitals should be eligible to receive Medicaid program incentive payments if they meet the definition of meaningful use. CMS' exclusion of CAHs from the Medicaid incentive program is contrary to the statute and inappropriate.

Hospital-Based Physician Definition

Separate and apart from the issue of meaningful use, we are concerned about CMS's proposed definition of a hospital-based physician. CMS' definition is very broad and inappropriately excludes physicians practicing in outpatient centers and clinics from being eligible for EHR incentive payments merely because their office or clinic is located in a facility owned by the hospital. Implementing an EHR in the ambulatory setting requires a significant cost for the hospital above and beyond the cost of the inpatient EHR. Therefore, this broad exclusion of physicians may inhibit hospital investments in their outpatient primary care sites, which runs counter to the intent of Congress in creating EHR incentive payments. Therefore, we urge you to define a hospital-based physician so as to exclude physicians practicing in outpatient centers and clinics.

For the purposes of this EHR incentive program, CMS should modify the scope of services it considers to be outpatient hospital services. Regardless of how the ambulatory care sites are licensed or established, the care and services furnished in these settings are similar to services furnished by private physician offices in other communities that are able to attract private physicians and clearly eligible under the statute to receive HIT incentive payments. Physicians practicing in hospital ambulatory care sites, particularly those located in health shortage areas, should not be disadvantaged relative to their peers practicing in more traditional private practice

settings from receiving HIT incentive payments. A broad interpretation of hospital-based physicians would inappropriately and inadvertently exclude many physicians furnishing ambulatory care services from eligibility for incentive payments and therefore, prevent patients in these communities from realizing the known benefits of EHRs such as care coordination.

Multi-Campus Hospital Limitation

In addition, the rule inappropriately limits the number of hospitals that are eligible to receive incentives and participate in the program. Specifically, CMS's proposal to use Medicare provider numbers to distinguish hospitals for EHR incentive payment purposes is not appropriate. In many facilities, a single provider number can include multiple campuses of a hospital system. If the Medicare provider number is used to define a hospital, a health care system with multiple hospital sites (but a single Medicare provider number) would receive one incentive payment for the entire health care system. This disadvantages and penalizes hospital systems with only one provider number relative to hospital systems with multiple provider numbers. For EHR incentive payment purposes, we ask that you identify hospitals as discrete facilities of service so that individual sites of hospitals are eligible to separately qualify for the incentives.

If you have any questions or wish to discuss this further, please don't hesitate to contact us directly.

Sincerely,