

March 2, 2010

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

Dear Ms. Frizzera,

We commend your leadership in bringing continued innovation and patient care improvements through health information technology (HIT). If implemented thoughtfully, HIT has the potential to reduce waste, reign in costs, and improve quality in our health care system.

We are writing to express several concerns with Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding Medicare and Medicaid incentives for "meaningful use" of electronic health records (EHRs). Specifically we are concerned about the proposed definition of meaningful use in Medicare and Medicaid, the inappropriate exclusion of most physicians working in outpatient centers, and the treatment of hospitals that have multiple campuses that use one provider number.

We urge you to modify your proposed definition of requirements for hospitals to become qualified as "meaningful users" of certified EHR technology. We are concerned that the CMS' proposed rule regarding Medicare and Medicaid incentives for meaningful use of EHRs is too restrictive and could result in many hospitals, particularly rural and safety-net providers, being financially penalized for an inability to comply.

Furthermore, the 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. The rule proposes an 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. We urge you to consider a longer transition that recognizes a practical, incremental approach to EHR adoption that rewards the efforts already underway in America's hospitals.

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.

As we strive for more technology standardization and certified EHR systems, we urge CMS to provide flexibility in the early years of the program to ensure that the certification process currently being discussed does not prevent hospitals and physicians from receiving these much needed funds when the program begins. Additionally, electronic reporting of quality measures through EHRs is a highly valued goal that is not yet possible to meet. Therefore, we urge CMS to defer the automated quality reporting requirement until all measures to be collected through EHRs can be re-specified, tested, and implemented.

The rule also inappropriately limits the number of professionals and hospitals that are eligible to receive incentives and participate in the program. Specifically, we are deeply concerned about CMS's proposed definition of a hospital-based physician. The definition is quite broad and inappropriately excludes physicians practicing in outpatient centers and clinics from being eligible for EHR incentive payments because their offices or clinics are located in facilities owned by the hospital system.

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 professions shortage areas, should not be disadvantaged relative to their peers practicing in more traditional private practice settings from receiving HIT incentive payments.

Additionally, CMS' 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.

Finally, the meaningful use regulation allows a lot of flexibility for states on how the HIT Medicaid incentive payments are made to hospitals and other eligible providers. We recognize that Medicaid is a state-federal program, but there should be some direction given to states to ensure that the incentive payments are made as a separate and distinct payment to providers so that they can be used, as the statute intended, to support HIT implementation. If the incentive payments are included in existing reimbursements, it will be harder to track the payments and the results of this investment in HIT. It also could negatively affect current payments that providers receive.

We appreciate your consideration on this issue and look forward to your response as we work to improve the quality and efficiency of our health care system through the use of EHR.

Sincerely,