American Hospital Association

HIT INCENTIVE PAYMENTS: DEFINITION OF A HOSPITAL

Summary of the Issue

The payment incentives in the *American Recovery and Reinvestment Act of 2009* (ARRA) are available to each hospital that is a meaningful user of a certified electronic health record (EHR); ARRA defines a hospital as a Medicare subsection (d) hospital, which is a general, acute care, short-term hospital. In the Centers for Medicare & Medicaid Services' (CMS') recently released rule on EHR incentive payments, the agency proposes to provide incentive payments to hospitals as distinguished by their Medicare provider number.

AHA's Position

We are concerned about CMS's proposal to use Medicare provider numbers to distinguish hospitals for EHR incentive payment purposes. There is no standard approach to exactly what facilities a Medicare provider number encompasses and in many facilities, a single provider number can include multiple sites of a hospital system. The Medicare and Medicaid payment incentives in ARRA are based on a base amount of $2 million plus a capped per-discharge amount per hospital. Therefore, 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 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 assigned a provider number for purposes of reporting to Medicare should put it at neither an advantage nor disadvantage. If the Medicare provider number is used to define a hospital for EHR incentive payment purposes, a health care system with multiple hospital sites and a single Medicare provider number representing all of their sites will be disadvantaged relative to others enumerated with multiple IDs because they will only be eligible for one base amount and are much more likely to reach the discharge cap. Hospital systems that have only one provider number should not be disadvantaged or penalized in the calculation of the incentive payments relative to hospital systems with multiple provider numbers.

The cost of EHR implementation at each site far exceeds the purchase cost of the actual application or software. Each site is at least, in part, an autonomous unit, with local systems and policies that must be independently reflected 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 site 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 facility of service, so that individual sites of hospitals are eligible to separately qualify for the

incentives. While CMS does not currently collect data by individual hospital site, it does have avenues through which it could do so, such as the cost report.