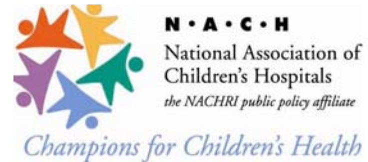

December 11, 2009

The Honorable Peter Orszag
Director
Office of Management and Budget
725 17th Street, N.W.
Washington, DC 20503

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

David Blumenthal
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 729-D
Washington, DC 20201

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

Dear Dr. Orszag, Ms. Sebelius, Dr. Blumenthal and Ms. Frizzera,

As the Centers for Medicare & Medicaid Services (CMS) prepares its proposed rule to implement the health information technology (HIT) provisions of the *American Recovery and Reinvestment Act of 2009* (ARRA), we would like to take this opportunity to comment on two aspects of the law. Bearing in mind that the purpose of ARRA is to encourage the adoption and use of electronic health records (EHRs), we would like to address the definition of a hospital and

the definition of a hospital-based eligible professional, both of which are key to ensuring that incentives are available to the greatest number of hospitals and physicians. We bring these issues to your attention ahead of publication of the proposed rule to avoid the possibility that their implementation will create barriers to and prevent the widespread adoption of HIT.

DEFINITION OF A HOSPITAL

The payment incentives contained in ARRA are available to each hospital deemed to be a "meaningful user" of a certified EHR. ARRA defines an "eligible hospital" as a Medicare subsection (d) hospital, which is a general, acute care, short-term hospital. While it may seem the simplest approach to rely exclusively on existing hospital identifiers, such as National Provider Identifiers (NPIs) or Medicare provider numbers, to define a hospital, we strongly caution CMS against doing so.

Defining hospitals solely by NPI or provider number could, contrary to the intent of ARRA, create a barrier to widespread EHR adoption and use. There is no standard policy that defines the specific types of hospital facilities to which an NPI or Medicare provider number apply. For example, NPIs may conceivably encompass small portions of hospitals, such as a single department, which clearly make them inappropriate to use in defining a hospital. In contrast, a single provider number may encompass multiple hospitals within a hospital system. Because the Medicare and Medicaid payment incentives in ARRA are calculated using a per-hospital base amount, plus a capped per-discharge amount per hospital, using only a provider number to define a hospital would result in ARRA incentives being distributed in a manner that does not foster widespread EHR adoption and use. Specifically, a health care system with multiple hospitals but a single Medicare provider number would be disadvantaged because the system would be eligible for only one base amount and much more likely to reach the discharge cap. In addition, such a health care system would be subject to HIT penalties at the system level, even if, for example, only one of the system's multiple hospitals was not found to be a meaningful user.

Linking HIT incentive payments only to the single Medicare provider number would not accurately reflect the deployment costs of all EHR systems across all hospitals in a system. The total cost of EHR implementation far exceeds the purchase cost of the actual application or software. Even hospitals that are part of the same system often require significant variations in their EHRs, as local policies and processes must be incorporated in EHR utilization. For example, installations must accommodate the differing network infrastructures of legacy software, physician preferences, clinical protocols, expert rules protocols, workflows and ancillary system integration. In addition, a hospital system may encompass both a children's hospital and an adult acute-care hospital, each of which requires a different interface and clinical system. Further, hospitals incur additional administrative costs for necessities such as workstation installation, servers, staff training and differences in clinical services among each of the hospitals, resulting in additional variation among facilities.

For HIT incentive payment purposes, we urge CMS not to use an NPI or Medicare provider number as the sole criterion to define a hospital. Instead, we ask CMS to use a

multi-pronged approach that allows a "hospital" to be defined in ways that acknowledge the varied organizational structure of multi-hospital systems, including by a distinct Medicare provider number, a distinct emergency department or a distinct state hospital license. Under this multi-pronged definition, each distinct hospital would then be eligible to qualify separately for the HIT incentives. CMS could use the hospital cost report, with certain modifications, to collect the hospital-specific data that will be necessary to determine the HIT incentive payment for each hospital.

DEFINITION OF A HOSPITAL-BASED ELIGIBLE PROFESSIONAL

The HIT payment incentives in ARRA also are available to qualifying eligible professionals, most of whom are likely to be physicians. However, ARRA excludes all hospital-based professionals from receiving incentive payments. These professionals are defined as those who furnish substantially all of their services in a hospital setting (whether inpatient or outpatient) using the facilities and equipment, including the qualified EHR, of the hospital. Several aspects of this statutory provision will need to be defined further in regulation. Specifically, we are concerned that an overly broad definition may inappropriately exclude eligible professionals who practice in outpatient centers and clinics merely because they provide patient care in an office or clinic that is located in a facility owned by a hospital.

Because of the inherent differences between the types of care provided, an ambulatory EHR is very different from an inpatient EHR. In fact, some physicians who treat patients in the ambulatory care setting may not provide care in the inpatient setting and, thus, may not even use the inpatient EHR. Implementing an EHR in an ambulatory setting requires a significant cost above and beyond the cost of implementing the inpatient EHR. In addition, it is not unusual for physicians to contribute financially to the cost of the ambulatory EHR, meaning that they are not furnishing their services using the hospital's facilities and equipment, including the EHR.

Excluding physicians practicing in hospital ambulatory care settings from eligibility for the HIT incentive payments would limit the benefit of EHR adoption in all communities, and especially in inner-city and rural settings. These inner-city and rural practice sites, which utilize an ambulatory EHR that is comparable or equivalent to the EHR platform used in traditional private practice settings, provide anchors to community-based services in their markets. In many cases, they are, in fact, the only available source of ambulatory care to thousands of people. Further, many of these clinic settings are being transformed to serve as the "medical home" for their patients, making EHR adoption, and therefore funding, critically necessary. Providing HIT incentive payment funding to physicians practicing in hospital ambulatory care settings will better support coordination all along the continuum of care for patients.

As CMS considers how to define a hospital-based eligible professional, the agency should take into account existing Medicare policies. We have identified two relevant Medicare policy precedents. The first relates to the term "substantially all," which is clearly defined in Medicare regulations with respect to graduate medical education (GME). Specifically, hospitals are able to receive GME funding for resident training programs in non-hospital settings if they incur "all or

substantially all of the costs for the training program," defined as at least 90 percent of these costs. **Under this precedent, we recommend that, for HIT purposes, CMS also define "substantially all" as at least 90 percent.**

The second precedent relates to the definition of a "hospital setting" with respect to CMS' physician e-prescribing policy. This policy measures whether and the extent to which a physician has adopted and uses a qualified e-prescribing system in the ambulatory setting.

The e-prescribing policy provides a path for CMS to identify and exclude from its definition of a "hospital setting" services that are provided in outpatient centers and clinics, even if these services are provided in a facility owned by the hospital. Specifically, the policy identifies services furnished in the ambulatory setting for which a specific group of non-emergency department procedural codes is used. The policy states that these codes – and, therefore, the ambulatory care setting (including outpatient centers and clinics) – are separate and distinct from the hospital setting, regardless of whether or not a hospital owns the facility. **We recommend that, for HIT purposes, CMS not consider services billed with the e-prescribing codes as services furnished in the hospital setting.**

We appreciate the opportunity to share these concerns and suggestions and look forward to working together to ensure that the HIT incentive program is appropriate and workable for hospitals, physicians and their patients.

Sincerely,

American Hospital Association
Association of American Medical Colleges
Federation of American Hospitals
National Association of Children's Hospitals
National Association of Public Hospitals and Health Systems

cc: Ms. Jodi Daniel, Director of Policy and Research, Office of the National Coordinator for Health Information Technology
Mr. Tony Trenkle. Director, Office of e-Health Standards and Services, Centers for Medicare & Medicaid Services