Representative Health Systems and Hospital Associations
Meeting with Office of Management and Budget
New Executive Office Building, 1 pm ET
July 2, 2010

Medicare & Medicaid
Electronic Health Record Incentive Program Proposed Rule
Multi-campus Issue

Agenda Item	*Presenter*	*Tab*
• Introductions, purpose of the meeting, review of key issues	Dr. Gary Bisbee	
• Electronic Health Records (EHRs) o Background and importance	Dr. Steven Safyer	
• ARRA HITECH Act o Congressional intent regarding multi-campus hospitals o Documentation of Congressional intent	Don Ashkenase, William Signer	2. 4. 5.
• Administrative solutions—remote location	David Rich	3.
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• Fairness and equity o Complexity and costs of information technology	Fred Hipp Phyllis Lantos	
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Participant List

In-person Participants

- Don Ashkenase, Special Advisor to the President, *Montefiore Medical Center*
- Gerald E. Bisbee, Ph.D., MBA, Chairman and CEO, *The Health Management Academy*
- Fred Hipp, Jr., Vice President, Government Relations, *Virtua Health*
- John David Hoppe, President, *Quinn Gillespie & Associates*
- Sherrie L. Jones, President, *The Health Management Academy*
- Phyllis Lantos, Executive Vice President and CFO, *New York Presbyterian Hospital*
- David Rich, Executive Vice President, *Greater New York Hospital Association*
- William A. Signer, Managing Director, *The Carmen Group*

Telephonic Participants

- Joe Carr, CIO, *New Jersey Hospital Association*
- Jarrett Lewis, Analyst, *The Health Management Academy*
- Steven Safyer, M.D., President and CEO, *Montefiore Medical Center*
- Elisabeth R. Wynn, Vice President Finance, *Greater New York Hospital Association*

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Representative Multi-hospital Systems and Hospital Associations

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Terminology and Facts

- A *multi-hospital system*, or health system, is a corporate grouping of two or more hospitals
- The AHA lists 400 multi-hospital systems
- The 100 largest multi-hospital systems account for 50% of the net patient revenue in the nation
- A *multi-campus hospital* is a hospital that shares a provider number, or CCN number, with another hospital in the multi-hospital system
- The hospital that holds the provider number is referred to as the primary hospital

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Multi-campus Model

- No national database aggregates multi-campus hospitals
- Conducted survey in May-June, 2010 of the largest 200 multi-hospital systems to determine number of multi-campus hospitals and annual discharges
- Projected results from survey to health systems 201-400
- Made meaningful use assumptions
  - Number hospitals meeting requirements
  - Hospitals phasing-in over next four years
- Assumed national average Medicare and Medicaid shares

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Multi-campus Hospital Survey

- Surveyed largest 200 multi-hospital systems, 5-6/2010
  - 158 multi-campus hospitals owned by 79 systems
  - Rate of multi-campus hospitals fell from 3.13 in health systems1-50 to 1.15 in health systems 151-200
- Applied the 1.15 rate to large health systems 201-400
  - Estimated 106 multi-campus hospitals
- The largest 400 multi-hospital systems own or operate an estimated 264 multi-campus hospitals
- Assumed an additional 5% multi-campus hospitals (13) for smaller health systems
- Total 277 estimated multi-campus hospitals

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Discharges/Hospital

- In same survey of 200 largest health systems, the average annual discharge/hospital was 14,055
- This included the multi-campus hospital(s) and the primary hospital (i.e., holder of the provider number)
- For example, if there were two multi-campus hospitals that shared a provider number with a primary hospital, the three hospitals would have each averaged 14,055 discharges
- The ARRA legislation specifies that the hospital would be eligible for a $200 per discharge payment from 1,150-23,000 discharges or 21,850 discharges ($4.37 Million)

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Meaningful Use Assumptions

- Estimated 60% of hospitals would meet meaningful use requirements
- Phase-in assumption
  - Year 1 55% hospitals would meet criteria
  - Year 2 25%
  - Year 3 20%
- Above assumptions based upon discussions with surveyed multi-hospital systems and vetted with AHA, AAMC, GNYHA, and Ways and Means staff
- Medicare and Medicaid shares
  - Assumed national average Medicare (0.43) and Medicaid (0.21) shares

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Calculated Payment per Hospital

- ARRA payments
  - $2 Million base payment per hospital
  - $200 per discharge for up to 21,850 discharges
- For multi-campus hospitals, added base payment and annual discharges and multiplied by:
  - Annual transition factor
  - Phase-in assumption
  - Medicare and Medicaid shares
  - Meaningful use assumptions
- Average multi-campus hospital averaged
  - $2.7 Million in Medicare payments
  - $1.3 Million in Medicaid payments
  - $4.0 Million total payments

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Fiscal Impact

- Fiscal impact for 277 multi-campus hospitals = $1.1 billion
- Offset from primary hospital receiving average discharges = $232 Million
  - 149 primary hospitals x 7,795 discharges x $200
  - (21,850 max discharges less 14,055 average discharges [from survey] = 7,795 discharges)
- Total projected fiscal impact = $882 Million

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The Academy Advisors Briefing
ARRA: Multi-campus Hospital Eligibility

Background: Intent of ARRA HIT Legislation

The health information technology (HIT) provisions in the American Recovery and Reinvestment Act of 2009 ("ARRA") establish payment incentives in the Medicare and Medicaid programs to encourage hospitals and physicians to adopt and use electronic health records (EHRs).

CMS' Interpretation has Narrowed the Definition of Eligible Hospital

The Medicare payment incentives in the ARRA are available to subsection (d) hospitals that are defined as "meaningful users" of a certified EHR. Rather than giving the language a simple, literal interpretation and allowing all "subsection (d) hospitals" to be eligible for incentive payments, CMS has proposed to provide incentive payments to hospitals as distinguished by their CMS Certification Number (CCN), or Medicare provider number. Multi-hospital systems, however, often have a single CCN for reasons of administrative convenience and, in certain cases, state regulations. This means that hospitals sharing a provider number (multi-campus hospitals) will not have the opportunity to qualify for the meaningful use payments which directly counters Congressional intent and these hospitals will be disadvantaged or penalized compared to hospital systems where each hospital has its own provider number.

Scope of the Multi-campus Issue

In order to determine the scope of this issue, The Academy Advisors conducted a survey in April-May 2010 of the 200 largest health systems, (based on net patient revenues) to determine the number of multi-campus hospitals. For the 200 health systems, 78 health systems had at least one multi-campus hospital.

We extended the ratios developed from our sample of the 200 largest health systems to the approximately 400 health systems (that own or operate 3,500 hospitals) as recognized by the American Hospital Association. We noted that the number of multi-campus hospitals declined 18% throughout the sample of 200. We applied the same ratio to the 201-400 health systems and arrived at a total of 264 multi-campus hospitals among the 400 large health systems. We expected that the larger health systems would have a greater number of multi-campus hospitals but assumed that health systems smaller than the largest 400 would also have some instances. We therefore added 13 hospitals (5% of 264), arriving at 277 multi-campus hospitals.

We modeled the impact if CMS were to recognize each hospital campus separately and provide a $2 million base payment and per discharge amount as we believe was intended in ARRA (see Table 1). We factored in the payment transition factors and assumed that 60% of multi-campus hospitals would qualify for meaningful use payments. We phased in the starting date for the hospitals that qualify over 2011-2013, at a rate of 55%, 25%, 20% respectively. We used the actual average number of annual discharges per hospital from the sampled health systems (14,055), and applied the national Medicare (0.43) and Medicaid (0.21) shares to develop an estimated payment amount per multi-campus hospital.

Table 1 shows that if CMS were to recognize each campus separately and provide the full ARRA payment, we estimate that the additional HIT incentive payments made to multi-campus hospitals would be $882 million through 2014. We reflected an offset of $232 million that would result from the per discharge amount for each campus being calculated based on the average, rather than actual, number of discharges per campus (subject to the discharge cap). The $882 million represents the potential impact assuming that each campus of a multi-campus hospital received the $2 million base payment and the average per discharge amount.

CMS Should Agree to Fulfill Congressional Intent

In order to fulfill Congressional intent, each hospital should have the opportunity to receive incentive payments if they meet meaningful use requirements. We ask legislators to reach out to CMS to request that they define each hospital meeting meaningful use requirements as eligible for incentive payments. The model outlined in this brief and the accompanying worksheet shows that payments made to multi-campus hospitals would amount to less than $1 billion.

The Academy Advisors
Table 1. Multi-campus Model - Base Payments

	Max Possible	Sample	Year 1	Year 2	Year 3	Year 4	Total
Transition Factor - 2011			1	0.75	0.5	0.25	
Transition Factor - 2012				1	0.75	0.5	
Transition Factor - 2013					1	0.75	
Transition Factor - 2014						0.75	
Phase-in Assumption			0.55	0.25	0.2	0	
Medicare Share - national average	0.43	0.43					
Medicaid Share - national average	0.21	0.21					
Base Payment	2,000,000	2,000,000					
Discharge Amount	200	200					
Discharges (14,055-1,150)	21,850	12,905					
Discharge Payment	4,370,000	2,581,000					
Meaningful Use Assumption	100	0.60					
Total Potential Medicare/Medicaid Payment	6,370,000	2,748,600					
Medicare Payment/Hospital - 2011			650,044	487,533	325,022	162,511	1,625,110
Medicare Payment/Hospital - 2012				295,475	221,606	147,737	664,818
Medicare Payment/Hospital - 2013					236,380	177,285	413,664
Total Medicare Payment/Hospital							2,703,592
Medicaid Payment/Hospital - 2011			317,463	238,097	158,732	79,366	793,658
Medicaid Payment/Hospital - 2012				144,302	108,226	72,151	324,678
Medicaid Payment/Hospital - 2013					115,441	86,581	202,022
Total Medicaid Payment/Hospital							1,320,359
Total Medicare/Medicaid Payments/Hospital			967,507	1,021,105	941,739	566,899	4,023,950
The Academy Model							
Sample: 200 health systems had 158 multi-campus hospitals							635,784,163
Note: 158 multi-hospitals from 200 largest health systems; estimated 106 from from health systems 201-400 and estimated 13 multi-hospitals from smaller health systems							**1,114,634,261**
Offset from primary hospital receiving average discharges							232,291,000
Total Projected CMS Payments							**882,343,261**

H.R.1 – American Recovery and Reinvestment Act of 2009

SEC. 4102(n)(6)(B)

ELIGIBLE HOSPITAL- The term 'eligible hospital' means a subsection (d) hospital.

CMS Proposed Regulations

SEC. (II)(B)(2)(a)

For purposes of this provision, we will provide incentive payments to hospitals as they are distinguished by provider number in hospital cost reports. Incentive payments for eligible hospitals will be calculated based on the provider number used for cost reporting purposes, which is the CCN of the main provider (also referred to as OSCAR number). Payments to eligible hospitals are made to each provider of record.

'(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of--

'(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

'(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

'(ii) the denominator of which is the product of--

'(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

'(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

'(E) TRANSITION FACTOR SPECIFIED-

'(i) IN GENERAL- Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

'(I) For the first payment year for such hospital, 1.

'(II) For the second payment year for such hospital, 3/4 .

'(III) For the third payment year for such hospital, 1/2 .

'(IV) For the fourth payment year for such hospital, 1/4 .

'(V) For any succeeding payment year for such hospital, 0.

'(ii) PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST ADOPTING EHR AFTER 2013- If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is

after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

`(F) FORM OF PAYMENT- The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

`(G) PAYMENT YEAR DEFINED-

`(i) IN GENERAL- For purposes of this subsection, the term `payment year' means a fiscal year beginning with fiscal year 2011.

`(ii) FIRST, SECOND, ETC. PAYMENT YEAR- The term `first payment year' means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms `second payment year', `third payment year', and `fourth payment year' mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

`(3) MEANINGFUL EHR USER-

`(A) IN GENERAL- For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for an EHR reporting period under such subsection for a fiscal year) if each of the following requirements are met:

`(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY- The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

`(ii) INFORMATION EXCHANGE- The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

`(iii) REPORTING ON MEASURES USING EHR- Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

`(B) REPORTING ON MEASURES-

`(i) SELECTION- The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

`(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

`(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

`(ii) LIMITATIONS- The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

`(iii) COORDINATION OF REPORTING OF INFORMATION- In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

`(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE-

`(i) IN GENERAL- An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include--

`(I) an attestation;

`(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

`(III) a survey response;

`(IV) reporting under subparagraph (A)(iii); and

`(V) other means specified by the Secretary.

`(ii) USE OF PART D DATA- Notwithstanding sections 1860D-15(d)(2)(B) and 1860D-15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D-15 that are necessary for purposes of subparagraph (A).

`(4) APPLICATION-

`(A) LIMITATIONS ON REVIEW- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of--

`(i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed-days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);

`(ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and

`(iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

`(B) POSTING ON WEBSITE- The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) (and a list of the names of critical access hospitals to which paragraph (3) or (4) of section 1814(l) applies), and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that an eligible hospital (or critical access hospital) has the opportunity to review the other relevant data that are to be made public with respect to the hospital (or critical access hospital) prior to such data being made public.

`(5) CERTIFIED EHR TECHNOLOGY DEFINED- The term `certified EHR technology' has the meaning given such term in section 1848(o)(4).

`(6) DEFINITIONS- For purposes of this subsection:

`(A) EHR REPORTING PERIOD- The term `EHR reporting period' means, with respect to a payment year, any period (or periods) as specified by the Secretary.

`(B) ELIGIBLE HOSPITAL- The term `eligible hospital' means a subsection (d) hospital.'.

sufficient Internet access. The exemption is subject to annual renewal, but in no case may an EP be granted a hardship exemption for more than 5 years.

We will include specific proposals to implement these payment adjustments for EPs who are not meaningful EHR users in future rulemaking prior to the 2015 effective date. We welcome comments on these payment adjustments and any comments received will be considered in developing future proposals to implement these provisions, including comments on the possible circumstances for which we should allow an EP to qualify for the significant hardship exception.

2. Incentive Payments for Hospitals

a. Definition of Eligible Hospital for Medicare

Section 1886(n) of the Act, as amended by section 4102(a)(1) of the HITECH Act, provides for incentive payments, beginning in FY 2011 (that is, October 1, 2010 through September 30, 2011) for eligible hospitals that are meaningful users of certified EHR technology during the EHR reporting period for the payment year. We are proposing a new §495.104 to implement this provision. For purposes of this provision, section 1886(n)(6)(B) of the Act defines "eligible hospitals" as "subsection (d) hospitals," as that term is defined in section 1886(d)(1)(B) of the Act. Section 1886(d)(1)(B) of the Act generally defines a "subsection (d) hospital" as a "hospital located in one of the fifty States or the District of Columbia." The term therefore does not include hospitals located in the territories or hospitals located in Puerto Rico. Section 1886(d)(9)(A) of the Act separately defines a "subsection (d) Puerto Rico hospital" as a hospital that is located in Puerto Rico and that "would be a subsection (d) hospital . . . if it were located in one of the 50 states." Therefore, because section 4102(a)(1) of the HITECH Act does not refer

to "subsection (d) Puerto Rico hospitals," incentive payments for meaningful users of certified EHR technology are not available under this provision to hospitals located in Puerto Rico. The provision does apply to inpatient, acute care hospitals located in the State of Maryland. These hospitals are not currently paid under the IPPS in accordance with a special waiver provided by section 1814(b)(3) of the Act. Despite this waiver, the Maryland hospitals continue to meet the definition of a "subsection (d) hospital" because they are located in the 50 states. The statutory definition of a subsection (d) hospital also does not apply to hospitals and hospital units excluded under section 1886(d)(1)(B) from the IPPS, such as psychiatric, rehabilitation, long term care, children's, and cancer hospitals. For purposes of this provision, we will provide incentive payments to hospitals as they are distinguished by provider number in hospital cost reports. Incentive payments for eligible hospitals will be calculated based on the provider number used for cost reporting purposes, which is the CCN of the main provider (also referred to as OSCAR number). Payments to eligible hospitals are made to each provider of record. The criteria for being a meaningful EHR user, and the manner for demonstrating meaningful use, are discussed in section B.2. of this proposed rule.

b. Incentive Payment Calculation for Eligible Hospitals

Section 1886(n)(2) of the Act, as amended by 4102(a) of HITECH, describes the methodology for determining the incentive payment amount for eligible hospitals that are meaningful users of certified EHR technology during the EHR reporting period for a payment year. In general, that section requires the incentive payment for each payment year to be calculated as the product of: (1) an initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year.

As amended by section 4201(a) of the HITECH Act, section 1886(n)(2)(A)(i) of the Act defines the initial amount as the sum of a "base amount," as defined in section 1886(n)(2)(B) of the Act, and a "discharge related amount," as defined in section 1886(n)(2)(C) of the Act. The base amount is $2,000,000, as defined in section 1886(n)(2)(B) of the Act. The term "discharge related amount" is defined in section 1886(n)(2)(C) of the Act as "the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) for the first through the 1,149th discharge, $0.
(ii) for the 1,150th through the 23,000th discharge, $200.
(iii) for any discharge greater than the 23,000th, $0.

In addition to the base amount, the discharge related amount provides an additional $200 for each hospital discharge during a payment year, beginning with a hospital's 1,150th discharge of the payment year, and ending with a hospital's 23,000th discharge of the payment year. No additional payment is made for discharges prior to the 1,150th discharge, or for those discharges subsequent to the 23,000th discharge.

Section 1886(n)(2)(C) of the Act, as amended by section 4102(a) of the HITECH Act, specifies that a "12-month period selected by the Secretary" may be employed for purposes of determining the discharge related amount. While the statute specifies that the payment year is determined based on a Federal fiscal year (FY), section 1886(n)(2)(C) of the Act provides the Secretary with authority to determine the discharge related amount on the basis of discharge data from a relevant hospital cost reporting period, for use in determining the incentive payment during a FY. FYs begin on October 1 of each calendar year, and end on September 30 of the subsequent calendar year. Hospital cost

reporting periods can begin with any month of a calendar year, and end on the last day of the 12th subsequent month. For purposes of administrative simplicity and timeliness, we propose, for each eligible hospital during each incentive payment year, to use data on the hospital discharges from the hospital fiscal year that ends during the FY prior to the FY that serves as the payment year as the basis for making preliminary incentive payments. Final payments would be determined at the time of settling the cost report for the hospital fiscal year that ends during the payment year, and settled on the basis of the hospital discharge data from that cost reporting period.

Example: FY 2011 begins on October 1, 2010 and ends on September 30, 2011. For an eligible hospital with a cost reporting period running from July 1, 2010 through June 30, 2011, we would employ the relevant data from the hospital's cost reporting period ending June 30, 2010 in order to determine the incentive payment for the hospital during FY 2011. This timeline would allow us to have the relevant data available for determining payments in a timely manner for the first and subsequent payment years. This timeline would also render it unnecessary to develop a cumbersome process to extract and employ discharge data across more than one hospital cost reporting period in order to determine the discharge related amount for a FY-based payment period. However, final payments would be based on hospital discharge data from the cost report ending June 30, 2011, and determined at the time of settlement for that cost reporting period.

c. Medicare Share

As previously discussed, the initial amount must be multiplied by the Medicare share and an applicable transition factor to determine the incentive payment to an eligible

a basic system." Computerized order entry for drugs was fully implemented in only 17 percent of hospitals.

Most physicians and hospitals have not yet invested in the hardware, software, testing and training to implement EHRs for a number of reasons – lack of standards, lack of interoperability, limited physician acceptance, fear of maintenance costs, and lack of capital. Perhaps most importantly, adoption of EHR technology necessitates major changes in business processes and practices throughout a provider's office or facility. Business process reengineering on such a scale is not undertaken lightly. However, the availability of the HITECH Act incentives, grants for technical support, more consistent use of standards and specified certification criteria, and other factors addressed in this RIA are sure to increase the adoption of EHR technology very substantially over the next 10 years—perhaps approaching complete adoption for physicians, hospitals, and many other types of providers.

Section II. of this proposed rule describes the categories of EPs, eligible hospitals, and CAHs under Medicare and Medicaid, and outlines the eligibility criteria, so those details are not repeated here.

Overall, we expect spending under the EHR incentive program for transfer payments to Medicare and Medicaid providers to be between $14 and $27 billion over 10 years (these estimates include net payment adjustments for providers who do not achieve meaningful use in 2015 and beyond in the amount of -$2.3 billion to -$5.1 billion). We have also estimated "per entity" costs for EPs and eligible hospitals, which aggregate to total spending. We estimate also that adopting entities will achieve dollar savings at least equal to their total costs, and that there will be additional benefits to society whose magnitude is uncertain, but will certainly be many billions of dollars over time.

REGULATORY PRECEDENTS FOR TREATING HOSPITALS WITHIN A MULTI-CAMPUS HOSPITAL SYSTEM AS SEPARATE ENTITIES FOR MEDICARE PAYMENT PURPOSES

On March 25, 2010, the Chairman of the House Ways and Means Committee, Sander Levin, along with the Chairman of the Health Subcommittee, Pete Stark, and Ways and Means member Charles Rangel, sent a letter to the Centers for Medicare and Medicaid Services (CMS) Acting Administrator Charlene Frizzera making clear that it was Congressional intent that each individual hospital campus should be treated as an individual hospital for the purposes of receiving health information technology (HIT) incentive payments under the American Recovery and Reinvestment Act (ARRA) HIT provisions, regardless of whether two hospitals share a CMS Certificate Number (CCN) for cost reporting purposes. The letter stated:

> The original legislative intent was to provide these payments to each hospital location of a multi-campus facility, known as "remote locations." As you work to finalize this regulation, we strongly urge you to make sure payments are available to each remote location, consistent with Congressional intent.

Beyond expressing Congressional intent, the Congressmen made clear that CMS has the regulatory authority to treat hospitals within a multi-hospital system as individual hospitals for Medicare payment purposes. The letter stated:

> CMS has often interpreted 1886(d) hospitals at the CCN level when implementing policy. However, precedent also exists to interpret 1886(d) to mean individual hospital facilities within a multi-hospital system, known as "remote locations" and defined as inpatient hospital services under the name, ownership, and financial and administrative control of the main provider (42 C.F.R. §413.65). More specifically, CMS has previously distinguished and uniquely identified remote location hospitals in a multi-hospital system in order to determine a wage index appropriate for each unique hospital's location (42 C.F.R. §412.64(b)(5)).

Below, we explore the background for the two references in the Congressmen's letter.

First, the "remote locations" regulation. This regulation is part of the regulation implementing the requirement of the Balanced Budget Act of 1997 that CMS create an outpatient prospective payment system (OPPS). The final rule was published in the *Federal Register* on April 7, 2000. The "remote locations" definition is part of the elaborate section of the rule establishing the requirements for a facility to be deemed "provider based", i.e., sufficiently affiliated with a hospital that it could bill under the OPPS rather than another fee schedule, such as the physician fee schedule.

The definition in the regulation of "remote location of a hospital" is as follows:

> *Remote location of a hospital* means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient

> hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital may not be licensed to provide inpatient hospital services in its own right, and Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term ''remote location of a hospital'' does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter.

While this applies to outpatient reimbursement, CMS went on to say that such a definition should apply to many different types of situations, including inpatient facilities:

> Although the Program Memorandum and proposed rules were issued in response to situations primarily involving outpatient facilities, we believe the policies set forth in these documents are **equally applicable to inpatient facilities**, and should be applied in the many cases in which a determination about inpatient facilities must be made. The rules would not prohibit two previously separate hospitals from merging to become a single provider. However, for either facility to be considered provider-based with respect to the main provider, the facility would have to meet the criteria in this final rule. To clarify the scope of application of these regulations, we have added a definition of ''remote location of a hospital'' and a reference to hospital satellite facilities to § 413.65(a) Definitions, and have clarified the wording of several later sections by including references to remote locations and satellites. We have defined a ''remote location of a hospital'' as a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section...Hospitals may acquire remote locations by various means, but often do so by mergers or acquisitions, in which a single hospital purchases other, previously separate hospitals, and operates them as remote locations that are not separately organized as departments, but instead furnish the same types of services as the original hospital. For example, a long-term care or other specialty hospital might acquire one or more other hospitals, terminate their separate participation in Medicare, but continue to use them as sites of the same type of care as the original hospital. Satellite facilities are currently defined in our regulations at § 412.22(h)(1) (for hospitals) and§ 412.25(e)(1) (for units). In general, a satellite facility is a part of a hospital (or of a hospital unit) that provides services in a building also used by another hospital, or in one or more buildings on the same campus as buildings also used by another hospital. Satellite status always involves co-location with another hospital, while remote locations are not co-located with other hospitals' facilities. [Emphasis added.]

The broad point on this subject is that there is no statutory basis whatsoever for the entire "provider based" regulation, including the definitions "remote location of a hospital" and "satellite facility." Clearly, CMS felt it had ample discretion to make up new definitions. CMS itself recognized this when it said in the preamble to the provider based rule:

> The Medicare law (section 1861(u) of the Act) lists the types of facilities that are regarded as providers of services, but does not use or define the term ''provider-based.'' However, from the beginning of the Medicare program, some providers, which we refer to in this section as ''main providers,'' have owned and operated other facilities, such as SNFs or HHAs, that were administered financially and clinically by the main provider. The subordinate facilities may have been located on the main provider campus or may have been located away from the main provider. In order to accommodate the financial integration of the two facilities without creating an administrative burden, we have permitted the subordinate facility to be considered provider-based. The determination of provider-based status allowed the main provider to achieve certain economies of scale. To the extent that overhead costs of the main provider, such as administrative, general, housekeeping, etc., were shared by the subsidiary facility, these costs were allowed to flow to the subordinate facility through the cost allocation process in the cost report. This was considered appropriate because these facilities were also operationally integrated, and the provider-based facility was sharing the overhead costs and revenue producing services controlled by the main provider.

Given this, it is clear that CMS has the discretion to treat each hospital within a multi-hospital system as a separate "remote location" for the purposes of providing ARRA HIT incentive payments.

Second, the wage index issue mentioned in the Congressmen's letter. This argument specifically deals with the type of situation at hand—treating two hospitals within a system as separate hospitals. The regulation at 42 CFR §412.64 states:

> For hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurred.

This regulation is effective for discharges occurring on or after October 1, 1988. This is the CMS discussion from the proposed rule, issued on May 27, 1988:

> Multicampus Hospitals. Some hospitals receiving payment under the prospective payment system are multicampus hospitals; that is, they consist of two or more separately located inpatient hospital facilities. We have received inquiries concerning how we determine the prospective payment rate for these hospitals when the various individual hospital facilities are located in areas with different prospective payment rates or wage indexes.
>
> Section 1886(c)(3)(D) of the Act, as amended by Section 4002(c)(1)(D) of Pub. L. 100-203 provides that prospective payment rates are established "for hospitals located *** in a large urban area or other urban area ***" and "for hospitals located in a rural area***." That is, the prospective payment rate is based on the geographic location of the hospital at which the discharge occurs rather than on any location such as, for example, the location of the headquarters of the multicampus facility that owns or operates the various individual hospital facilities, or the location of the main hospital facility. Therefore, we

would amend §412.63 [LATER, §412.64] to provide that a multicampus hospital that qualifies as a single provider must be paid prospective payment rates that are determined by the geographic location of each individual hospital facility within the multicampus hospital.

This of course has the impact of saving the Medicare program money by, for instance, ensuring that a multicampus hospital in New York City would only get the NYC wage index for hospitals in the NYC wage index area, while its hospitals on Long Island would get the lower wage index applicable to Long Island. It is clear, though, that CMS is able to distinguish hospitals by campus for this purpose.

Attached is a description of the process CMS created to identify separate campuses within a multi-campus system for the purpose of applying separate wage indices. A similar process could be used to identify separate campuses within a multi-campus system for the purposes of ARRA HIT incentive payments.

Prepared by the Greater New York Hospital Association, July 2010.

CMS Reg/Program Transmittals on Separate Campuses for Wage Index Purposes

See http://www.ingenix.com/content/attachments/R1067CP.pdf for the actual document.

CMS instructed FIs/MACs to identify separate campuses by means of unique identifier (Pub. 100-04 Medicare Claims Processing, Transmittal 1067, Change Request 5276, September 26, 2006 (page 8)):

> Under our current policy, a multicampus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the CBSA (or metropolitan division, where applicable) in which the campus of the hospital is located. When the satellite campus is located in a different labor market area, the fiscal intermediary should assign a unique identifier (usually a 2 digit suffix), which is added after the provider's Online Survey Certification and Reporting (OSCAR) number. This provider-specific "suffix" will ensure the campus-specific payment is based on the wage index for the labor market area where the campus is geographically located.

There is also helpful language describing this situation at 74 Fed. Reg. 43843, Aug. 27, 2009:

> In the FY 2008 final rule with comment period (72 FR 47317) and the FY 2009 IPPS final rule (73 FR 48582), we discussed our policy for allocating a multicampus hospital's wages and hours data, by full-time equivalent (FTE) staff, among the different labor market areas where its campuses are located. During the FY 2010 wage index desk review process, we requested fiscal intermediaries/MACs to contact multicampus hospitals that had campuses in different labor market areas to collect the data for the allocation. As we proposed, the FY 2010 wage index in this final rule includes separate wage data for campuses of three multicampus hospitals.
>
> For FY 2010, we are again allowing hospitals to use FTE or discharge data for the allocation of a multicampus hospital's wage data among the different labor market areas where its campuses are located. The Medicare cost report was updated in May 2008 to provide for the reporting of FTE data by campus for multicampus hospitals. Because the data from cost reporting periods that begin in FY 2008 will not be used in calculating the wage index until FY 2012, a multicampus hospital will still have the option, through the FY 2011 wage index, to use either FTE or discharge data for allocating wage data among its campuses by providing the information from the applicable cost reporting period to CMS through its fiscal intermediary/MAC. Two of the three multicampus hospitals chose to have their wage data allocated by their Medicare discharge data for the FY 2010 wage index. One of the hospitals provided FTE staff data for the allocation. The average hourly wage associated with each geographical location of a multicampus hospital is reflected in Table 2 of the Addendum to this final rule.

United States Senate

WASHINGTON, DC 20510

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, rein in costs, and improve quality in our health care system.

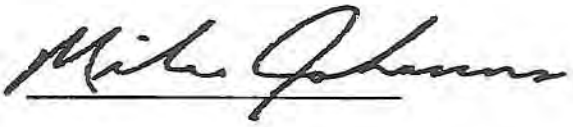
We are writing to express several concerns with Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding Medicare and Medicaid incentives for "meaningful use" of electronic health records (EHRs). Specifically we are concerned about the proposed definition of meaningful use in Medicare 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.

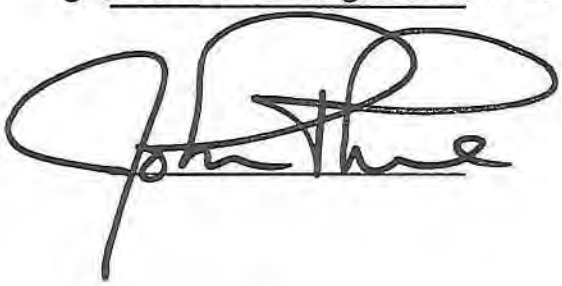
We urge you to modify your proposed definition of requirements for hospitals to become qualified as "meaningful users" of certified EHR technology. We are concerned that the CMS' proposed rule regarding Medicare and Medicaid incentives for meaningful use of EHRs is too restrictive and could result in 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





Congress of the United States
Washington, DC 20515

March 15, 2010

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;

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- 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,

ZACK SPACE
Member of Congress

MICHAEL C. BURGESS
Member of Congress

ELIOT ENGEL
Member of Congress

CLIFF STEARNS
Member of Congress

Space-Burgess-Engel-Stearns – Health IT Letter

Sponsors: Zack Space (D-OH-18), Michael Burgess, (R-TX-26), Eliot Engel (D-NY-17), Cliff Stearns (R-FL-6)
Status: CLOSED
Signatures: 249 (144 Democrats, 105 Republicans)
As of: 7:30 PM EST – March 15, 2010

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

March 25, 2010

Ms. Charlene Frizzera
Acting Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Subject: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule; Vol 75, No 8, January 13, 2010, **CMS-0033-P**

Dear Ms. Frizzera:

We write to share with you our view of Congressional intent in enacting the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions in the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5). We are troubled by a provision in the Proposed Rule to implement the HITECH Act and are in a unique position to relay Congressional intent. Each of us played a strong role in the development of this legislation, either as sponsor or cosponsor of the Health-e Information Technology Act of 2008 (H.R. 6898)- which served as the foundation for the HITECH Act - or as cosponsor of the HITECH Act.

We are concerned with how the Proposed Rule defines which hospitals are eligible to receive incentive payments to adopt and meaningfully use electronic health record (EHR) technology. The original legislative intent was to provide these payments to each hospital location of a multi-campus facility, known as "remote locations." As you work to finalize this regulation, we strongly urge you to make sure payments are available to each remote location, consistent with Congressional intent. This change is needed in order to ensure that the Act has its maximum intended impact on improving health care quality, safety, and value for Americans. Below are suggestions for resolving this problem.

In ARRA, Congress defined hospitals eligible for incentive payments as "1886 subsection (d)" hospitals (Pub. L. 111-5, Sec. 4102(n)(6)(B)). In the Proposed Rule, CMS interpreted this to mean subsection (d) hospitals defined exclusively by their national provider number, the CMS Certificate Number (CCN) in hospital cost reports. This limited interpretation of the statute is contrary to Congress' intent in ARRA and will be an obstacle to widespread adoption and use of EHRs. This narrow interpretation would exclude many hospitals that are "*remote locations*" of the main provider hospital and operate under a single provider number in *multi-hospital systems*. A single provider number may encompass multiple hospital campuses in such a system. These multi-hospital systems would get only one Medicare incentive payment under this proposed rule, rather

than payments to each hospital facility. Multi-hospital systems would also be more likely to exceed the annual discharge cap of 23,000. Therefore, using only the provider number to identify eligible hospitals would unfairly disadvantage and penalize multi-hospital systems and limit the impact of HITECH incentives to foster EHR adoption and meaningful use.

We strongly recommend that CMS expand its definition for eligible hospitals for purposes of Medicare payment incentives under the HITECH Act such that remote location hospitals of multi-hospital systems will each be eligible for incentives to adopt and use EHRs.

CMS has often interpreted 1886(d) hospitals at the CCN level when implementing policy. However, precedent also exists to interpret 1886(d) to mean individual hospital facilities within a multi-hospital system, known as "remote locations" and defined as inpatient hospital services under the name, ownership, and financial and administrative control of the main provider (42 C.F.R. §413.65). More specifically, CMS has previously distinguished and uniquely identified remote location hospitals in a multi-hospital system in order to determine a wage index appropriate for each unique hospital's location (42 C.F.R. §412.64(b)(5)).

To make this change, CMS will need to be able to identify, pay, and penalize each remote location hospital in multi-hospital systems. CMS can identify such multi-hospital systems by adding a question to its annual cost report survey that asks each main provider hospital to identify the name, physical location, and number of FTEs at each remote location hospital aggregated under the main provider hospital CCN. An alternative approach is for CMS to direct Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) to obtain this information. CMS has previously directed FIs and MACs to create a "provider-specific suffix" as unique identifiers for individual hospitals of multi-hospital systems to ensure that campus-specific payment is based on the wage index for the labor market area where the campus is geographically located (Pub. 100-04 Medicare Claims Processing, Transmittal 1067, Change Request 5276, September 26, 2006).

Once multi-hospital systems are thus identified, CMS can determine the applicable incentive payment amount for each hospital within a multi-hospital system in one of two ways. The simpler approach is to use aggregate discharge data and Medicare share across the entire multi-hospital system. The main provider hospital and each remote location hospital would receive the sum of their own base amount ($2 million each) and a pro-rata share of the discharge-related amount (based on total system discharges/number of hospitals in system), multiplied by the Medicare share percentage for the entire multi-hospital system and the transition factor.

A hospital-specific approach would require CMS to collect the necessary data in annual cost reports on hospital discharges and Medicare share from each remote location within a multi-hospital system.

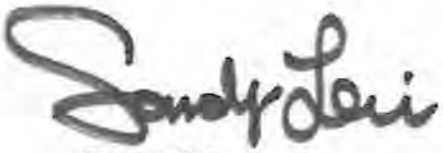
To operationalize this incentive program for remote locations of multi-hospital systems, CMS will need to develop a strategy to determine whether each remote location hospital meets criteria for meaningful use of EHRs. Payment adjustments for hospitals not meeting criteria for meaningful use of EHRs are to start in 2015 and mechanisms for this will be specified in future CMS rulemaking.

These adjustments would similarly need to be determined and applied at the remote location hospital level, rather than for the entire multi-hospital system.

In conclusion, we strongly urge you to resolve this issue in the Electronic Health Record Incentive Program Final Rule. We request that CMS define hospitals in this Final Rule in a way that acknowledges the varied organizational structures of multi-hospital systems and does not penalize such remote location hospitals. Providing incentives to adopt and meaningfully use EHR systems for each inpatient hospital is what Congress intended in this statute. This broader interpretation is consistent with CMS precedent and there are feasible mechanisms to accomplish this change. This change will maximize the impact of this statute on improving health care quality, safety, and value for Americans.

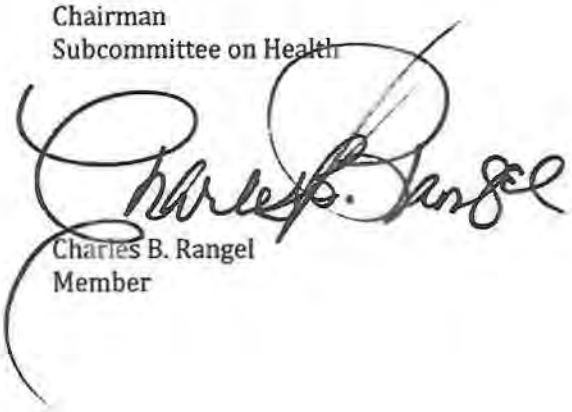
If you have questions about this letter, please feel free to contact Jennifer Friedman, Committee on Ways and Means, at 202-225-3943.

Sincerely,



Sander M. Levin
Chairman

Pete Stark
Chairman
Subcommittee on Health



Charles B. Rangel
Member

May 6, 2010

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

Dear Secretary Sebelius:

The undersigned grassroots coalition of multihospital health systems represent 142 hospitals, nearly 30,000 beds, net patient revenue of $33 billion and operate hospitals in 21 states. These health systems are very supportive of expanding use of electronic health records to increase quality and efficiency of healthcare.

We write to express our disappointment related to the Notice of Proposed Rule Making (NPRM) by the Centers for Medicare and Medicaid Services (CMS) on section 4102 of the American Recovery and Reinvestment Act (ARRA, P.L. 111-5). CMS's interpretation of section 4102 (a)(n)(6)(B) disregards Congressional intent to ensure that all "subsection (d) hospitals," including some of the nation's highest quality providers, are eligible for incentive payments for Electronic Health Record (EHR) investments under this section.

The ARRA legislation established incentive payments for hospitals who are meaningful users of EHR beginning in the year 2011. The ARRA legislative language is clear in defining the hospitals that are eligible for such payments, simply as "subsection (d) hospitals." However, CMS, in proposed rules, has limited the scope of eligible hospitals by stating that incentive payments will be provided only to hospitals that hold an OSCAR number (provider number). Because many hospitals within large health systems share provider numbers, numerous hospitals will be left without the ability to earn the incentive payments even though they must meet the meaningful use requirements.

It is necessary for each hospital to have the ability to receive incentive payments to encourage EHR use that will increase quality, accelerate efficiencies and promote the exchange of data with other healthcare providers. Because CMS has clearly not followed Congressional intent and this is a significant issue to inpatient acute care hospitals, we are requesting you to resolve this matter administratively.

We thank you for your attention to this issue, which is critically important to the undersigned as well as many other hospitals and hospital systems.

Yours sincerely,

Secretary Sebelius
May 6, 2010

Richard Afable, M.D.
Hoag Memorial Hospital Presbyterian, President & CEO
Newport Beach, California

Jeffrey R. Balser, M.D.
Vanderbilt Medical Center, Vice Chancellor for Health Affairs
Nashville, Tennessee

Donald L. Jernigan
Adventist Health System, President & CEO
Winter Park, Florida

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Bon Secours Health System, Inc., President & CEO
Marriottsville, Maryland

Nick W. Turkal, M.D.
Aurora Health Care, President & CEO
Milwaukee, Wisconsin

Stephen A. Williams
Norton Healthcare, President & CEO
Louisville, Kentucky

March 2, 2010

Honorable Max Baucus
Chairman, Finance Committee
511 Hart Senate Office Building
Washington, DC 20510-2602

Honorable Charles Grassley
Ranking Minority Member, Finance Committee
135 Hart Senate Office Building
Washington, DC 20510-1501

Dear Senators Baucus and Grassley:

The undersigned grassroots coalition of multihospital health systems represent 142 hospitals, nearly 30,000 beds, net patient revenue of $33 billion and operate hospitals in 21 states. These health systems are very supportive of expanding use of electronic health records to increase quality and efficiency of healthcare.

We write to express our disappointment related to the Notice of Proposed Rule Making (NPRM) by the Centers for Medicare and Medicaid Services (CMS) on section 4102 of the American Recovery and Reinvestment Act (ARRA, P.L. 111-5). CMS's interpretation of section 4102 (a)(n)(6)(B) disregards Congressional intent to ensure that all "subsection (d) hospitals," including some of the nation's highest quality providers, are eligible for incentive payments for Electronic Medical Record (EMR) investments under this section. This concern is in addition to and distinct from the question of which physicians can qualify for incentive payments by engaging in "meaningful use" of EHRs.

The ARRA legislation established incentive payments for hospitals who are meaningful users of EHR beginning in the year 2011. The ARRA legislative language is clear in defining the hospitals that are eligible for such payments, simply as "subsection (d) hospitals." However, CMS, in proposed rules, has limited the scope of eligible hospitals by stating that incentive payments will be provided only to hospitals that hold an OSCAR number (provider number). Because many hospitals within large health systems share provider numbers, numerous hospitals will be left without the ability to earn the incentive payments by being meaningful users of EHR. Please see the attachment for additional detail and proposed legislative language to fix this issue.

It is necessary for each hospital to have the ability to receive incentive payments to encourage EHR use that will increase quality, accelerate efficiencies and promote the exchange of data with other healthcare providers. Because CMS has clearly not followed Congressional intent and this is an issue of imminent importance to inpatient acute care hospitals, we are seeking legislative relief and propose wording in the attachment. It is our belief that the proposed legislative language is budget neutral.

We hope you will address this matter with your colleagues and resolve it through legislative means. We thank you for your attention to this issue, which is critically important to us as well as many other hospitals and hospital systems.

The following organizations have reviewed the attached document and strongly encourage members of the Senate to consider the recommendations included therein.

Senators Baucus and Grassley
March 2, 2010

Richard Afable, M.D.
Hoag Memorial Hospital Presbyterian, President & CEO
Newport Beach, California

Jeffrey R. Balser, M.D.
Vanderbilt Medical Center, Vice Chancellor for Health Affairs
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March 2, 2010

Attachment

Current Statutory Language

The definition of "eligible hospital" in Section 4102(a)(1) (amending 42 U.S.C. 1395ww by adding new subsection (n)(6)(B)) of ARRA is clear:

> ''(B) ELIGIBLE HOSPITAL.—The term 'eligible hospital' means a subsection (d) hospital.''

Section 1886(d)(1)(B) of the Social Security Act defines a "subsection (d) hospital" as a "hospital located in one of the fifty States or the District of Columbia."

CMS' Interpretation Has Narrowed the Definition of "Eligible Hospital"

Rather than giving the language a simple, literal interpretation and allowing all 'subsection d' hospitals to be eligible for incentive payments, CMS has proposed to pay incentive payments to hospitals as distinguished by Medicare provider number. This means multi-campus hospital systems that have one provider number may be disadvantaged or penalized in the calculation compared to hospital systems with multiple provider numbers.

Proposed Statutory Language

SEC. ____. CALCULATION OF HEALTH INFORMATION TECHNOLOGY INCENTIVE PAYMENTS FOR MULTI-FACILITY HOSPITALS.

(a) Medicare Incentives for Hospitals.—Section 1886(n)(2) of the Social Security Act (42 U.S.C. 1395ww(n)(2)), as added by section 4102(a)(1) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat 477), is amended by adding at the end the following new subparagraph:

"(H) Calculation of payment amount for multi-facility hospitals.—

"(i) In general.—In the case of an eligible hospital that is a multi-facility hospital (as defined in clause (ii)(I)), the Secretary shall treat each inpatient facility (as defined in clause (ii)(II)) of such multi-facility hospital as a separate eligible hospital under this subsection for purposes of payment under this subsection.

"(ii) Definitions.—In this subparagraph:

"(I) Multi-facility hospital.—The term 'multi-facility hospital' means a subsection (d) hospital for which the Secretary has issued a certification number that includes one or more inpatient facilities that furnish inpatient hospital services for which payment is made under this section under the same certification number issued to that subsection (d) hospital.

"(II) Inpatient facility.—The term 'inpatient facility' means, with respect to a multi-facility hospital, a facility that provides inpatient services and operates under the certification number of the multi-facility hospital, and that can demonstrate one of the following:

"(aa) the presence of an emergency department; or

"(bb) the presence of a separate state hospital identifier or license.".

(b) Medicaid Incentives for Hospitals.—Section 1903(t)(5) of the Social Security Act (42 U.S.C. 1396b(t)(5)), as added by section 4201(a)(2) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat 492), is amended by adding at the end the following new subparagraph:

"(E) Calculation of payment amount for multi-facility hospitals.—

"(i) In general.—In the case of a Medicaid provider described in paragraph (2)(B) that is a multi-facility hospital (as defined in clause (ii)(I)), the Secretary shall treat each inpatient facility (as defined in clause (ii)(II)) of such multi-facility hospital as a separate Medicaid provider described in paragraph (2)(B) under this subsection for purposes of payment under this subsection.

"(ii) Definitions.—In this subparagraph:

"(I) Multi-facility hospital.—The term 'multi-facility hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) for which the Secretary has issued a certification number under title XVIII that includes one or more inpatient facilities that furnish inpatient hospital services for which payment is made under this title under the same certification number issued to that subsection (d) hospital (as so defined).

"(II) Inpatient facility.—The term 'inpatient facility' means, with respect to a multi-facility hospital, a facility that provides inpatient services and operates under the certification number of the multi-facility hospital, and that can demonstrate one of the following:

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"(bb) the presence of a separate state hospital identifier or license.".

(c) Effective Date.—The amendments made by this section shall take effect as if included in the enactment of sections 4102(a)(1) and 4201(a)(2), respectively, of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

March 3, 2010

Honorable Pete Stark
Interim Chairman, Committee on Ways and Means
239 Cannon House Office Building
Washington, DC 20515-0513

Honorable Henry Waxman
Chairman, Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, DC 20515-0530

Honorable Dave Camp
Ranking Minority Member, Committee on Ways and Means
341 Cannon House Office Building
Washington, DC 20515-2204

Honorable Joe Barton
Ranking Minority Member, Committee on Energy and Commerce
2109 Rayburn House Office Building
Washington, DC 20515-4306

Dear Representatives Stark, Waxman, Camp and Barton:

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March 3, 2010

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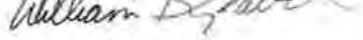

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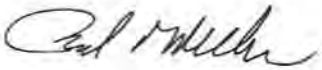

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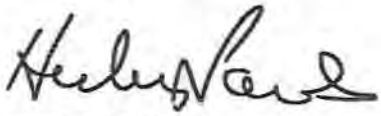

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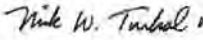

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March 3, 2010

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