

STATEMENT OF

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ON

**IMPLEMENTATION OF THE HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL
HEALTH ACT OF 2009 (HITECH) ACT**

BEFORE THE

**U.S. HOUSE COMMITTEE ON
ENERGY AND COMMERCE, SUBCOMMITTEE ON HEALTH**

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CMS TESTIMONY

Electronic Health Records (EHR) Medicare/Medicaid Incentive Payment Program

U.S. House Committee on Energy and Commerce

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Hearing on Health Information Technology

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Chairman Pallone, Ranking Member Shimkus, and Members of the Subcommittee, thank you for the invitation to discuss the health information technology provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act, P.L. 111-5), including the Centers for Medicare & Medicaid Services' (CMS) new incentive program for electronic health records (EHRs).

Background

Through the Health Information Technology for Economic and Clinical Health (HITECH) provisions within the Recovery Act, Congress established incentive payments for adoption and meaningful use of certified EHR technology by achieving specified objectives. The law authorizes incentive payments from the Medicare program to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), for successful demonstration of meaningful use. Under the Medicaid program, EPs and eligible hospitals, including CAHs, can receive incentive payments for efforts to adopt, implement, upgrade or meaningfully use certified EHR technology in their first payment year but must demonstrate meaningful use in subsequent years. Also, starting in 2015, Medicare EPs, eligible hospitals, and CAHs must demonstrate meaningful use in order to avoid negative Medicare payment adjustments in future years.

CMS has been working closely with the Department of Health & Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) to develop the policies needed to implement the Medicare and Medicaid EHR incentive programs.

Certified EHR technology used in a meaningful way is a critical aspect of a broader health information technology (HIT) infrastructure needed to reform our nation's health care

system. Announcement of these final rules marks the completion of multiple steps that lay the groundwork for the incentive payments program, which will help to improve health care quality, efficiency, and patient safety. The adoption of certified EHRs by providers has the potential to improve the health care delivery system while reducing waste through reductions of duplicate services and avoidance of preventable medical errors. The latest actuarial analysis estimates that payments will total between \$9.7 billion and \$27.4 billion over the next ten years.

CMS published a proposed regulation on January 13, 2010 to define meaningful use (CMS-0033-P) and describe the eligibility and payment methodologies for the incentive program created by the Recovery Act. ONC concurrently announced an interim final rule to outline the initial standards and certification criteria for EHRs. The ONC regulation defines the functional requirements needed to certify that a complete EHR or EHR module has the capability to meet the meaningful use requirements. ONC and CMS have worked jointly to review comments, develop coordinated language, and ensure that the two regulations are properly linked.

In response to the proposed rule, CMS received more than 2,000 comments from interested stakeholders who will be affected by EHR technology, including health care providers and patients. The Agency carefully reviewed and considered all submitted comments and took them into account in making policy decisions for the final rule. The final EHR incentive program rule incorporates changes that are designed to make the requirements achievable while meeting the goals of the HITECH Act. The final rule to implement the initial stage of these programs was put on display at the Federal Register on July 13, 2010.

Key Components of the CMS Regulation

The final regulation incorporates the HITECH statutory requirements and also balances two goals: encouraging eligible professionals and hospitals to adopt EHRs, but also having providers use EHRs in a meaningful way. The following sections describe the key components of the regulation as they pertain to the Medicare and Medicaid programs.

Eligible Professionals

The final rule adopts the statutory language defining a Medicare EP as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who is legally authorized to practice under State law.

A qualifying EP is one who demonstrates meaningful use for the EHR reporting period, as defined by the regulation. EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs may participate in only one program and must designate the program in which they would like to participate.

Under the statute, Medicaid defined an EP differently than Medicare. The final rule adopts the statutory language allowing five types of eligible professionals to qualify for Medicaid incentive payments: physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants (PAs) insofar as the PA works in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is so led by a PA. With the exception of pediatricians, eligible professionals must either have 30 percent Medicaid patient volume or they must practice predominantly in an FQHC or RHC and have 30 percent of their patient volume derived from needy individuals. Pediatricians may participate at a reduced patient volume threshold (20 percent), but if their Medicaid patient volume is between 20 and 30 percent, they receive a reduced incentive payment. In regulation, CMS defines how patient volume may be calculated, what it means to “practice predominantly,” and adopts the statutory definition of “needy individuals.”

The Recovery Act initially precluded hospital-based eligible professionals that provide “substantially all” of their services in an inpatient or outpatient hospital from receiving incentive payments. However, the Continuing Education Extension Act of 2010 modified the statutory definition of a hospital-based EP to include only those EPs providing substantially all of their services in inpatient departments and emergency rooms, thereby permitting hospital-based EPs in outpatient clinics or departments to receive incentive payments. CMS defined “substantially all” to mean 90 percent or more of allowed services, meaning that all EPs who provide more than 10 percent of their services in settings other than inpatient hospital departments or emergency room departments may be eligible for EHR incentive payments. The provisions in the final rule allow

EPs that practice exclusively in hospital outpatient departments to qualify for an incentive payment if they adopt and meaningfully use certified EHR technology.

Under the final rule, incentive payments will be made to qualifying Medicare Advantage (MA) organizations for the adoption and meaningful use of EHR technology by their affiliated EPs. Qualifying MA-Affiliated EPs are EPs who are employed or subcontracted by an MA organization and on average provide at least 20 hours of patient care services per week. For a subcontracted EP, at least 80 percent of his or her professional services should be furnished to enrollees of the MA organization. Each MA organization must attest and maintain evidence and documentation showing that their qualified affiliated EPs are meaningful users of certified EHR technology.

Eligible Hospitals

Consistent with the Medicare statute, CMS defines EHR incentive program eligibility for hospitals as a “subsection (d) hospital” that is paid under the hospital inpatient prospective payment system. In order to receive a Medicare incentive payment, these hospitals must be located in one of the 50 states or the District of Columbia. In order for a Medicare-eligible hospital to qualify for this incentive payment, the hospital must be able to demonstrate their meaningful use for the EHR reporting period during the Federal Fiscal Year (FY). Hospitals qualifying for the Medicare and Medicaid program can receive payments under both programs.

Consistent with the Medicaid statute, there are two types of hospitals that may participate in the Medicaid incentive program: acute care hospitals and children’s hospitals. In regulation, CMS defined acute care hospitals so that primarily short-term, general hospital stays qualify, as do CAHs and cancer hospitals. Acute care hospitals must have 10 percent of their patient volume derived from Medicaid. Per the statute, there are no patient volume requirements for children’s hospitals. It is worth noting that many Medicaid eligible hospitals can also qualify for Medicare hospital incentives. Largely these include: Medicaid acute care hospitals that are also Medicare subsection(d) hospitals and CAHs.

Under both programs, the EHR incentive payment for each eligible hospital that demonstrates meaningful use is calculated as the product of:

- (1) An initial amount which is the sum of a \$2 million base amount and the product of a per discharge amount and the number of discharges;
- (2) The proportion of fee-for-service and managed care inpatient bed-days (attributable to either Medicaid or Medicare, depending on which EHR incentive program) for the eligible hospital to the product of total inpatient days and by the hospital's proportion of total charges that are not attributed to charity care; and
- (3) A transition factor which phases down the incentive payments over the four year period.

Consistent with all other areas of the Medicare and Medicaid programs, CMS will treat all hospitals with one CMS Certification Number (CCN) (frequently referred to as the "provider number") as one hospital for the purposes of this incentive program.

There was interest from stakeholders that CMS accommodate multi-campus hospitals with a single CCN to allow each campus within the hospital to receive a separate EHR incentive payment. CMS carefully reviewed these comments and met with interested stakeholders, including the two largest hospital associations, the American Hospital Association and the Federation of American Hospitals, to hear their concerns with the policy described in the proposed rule. Taking this input as well as the legislative language of the Recovery Act into account, we came to the conclusion in our final rule that we should define hospitals consistently for all policy purposes including the Medicaid and Medicare EHR incentive payments. For the Medicare incentive payments, the statute defines a hospital as a subsection (d) hospital. Historically, a subsection (d) hospital has been treated as the entire institution and not each campus that is under the CCN. Allowing each campus of one hospital to be considered its own hospital for purposes of EHR incentive payments, but not for other purposes, would inappropriately distinguish EHR incentives from other payment and program participation policies without clear statutory direction to do so. To avoid this inconsistent treatment, CMS must have a consistent definition of a hospital for all policies, including EHR incentive payments, unless otherwise specified by law.

For example, under the Medicare program, a multi-campus hospital with a single CCN whose aggregate share of low-income patients is below 15 percent does not qualify for disproportionate share hospital (DSH) payments. However, without a consistent definition of a

hospital, a multi-campus hospital operating a single provider number could argue that an “eligible hospital” for purposes of DSH payments should be defined as an individual campus in instances where the individual campus has a share of low-income patients that is 15 percent or more. These individual facilities would therefore qualify for DSH payments if the campus was treated as a separate hospital. If we changed our definition of a hospital in response to such an argument, it could disadvantage other hospitals. Under current policy, a hospital receives DSH payment on all of its discharges if the entire hospital is eligible for DSH payments. In other words, if a hospital’s aggregate share of low-income patients is 15 percent or more, the hospital receives DSH payments even if individual campuses’ shares may be under 15 percent. Under this scenario, if each campus of a multi-campus hospital were treated as an individual hospital, it is possible the hospital would receive less in Medicare DSH payments.

In addition, with regard to graduate medical education, direct graduate medical education (DGME) payments for teaching hospitals are based on hospital-specific per resident amounts (PRA) and the hospital's Medicare patient share. A multi-campus hospital receiving DGME payments is paid based on a single PRA and the Medicare share for the entire hospital. However, if there is no consistent view of what constitutes the "hospital," such a multi-campus hospital could argue that each campus is a separate hospital, and manipulate its resident counts to maximize Medicare graduate medical education payments based upon different PRAs and Medicare shares at various campuses.

In each of these situations, an inconsistent definition of hospital for purposes of the EHR incentives program has implications regarding our policies in other contexts, such as the ones mentioned above. Accordingly, to protect the integrity of other Medicare payment policies and to avoid treating hospitals differently without clear statutory direction to do so, CMS determined in the final rule that it is necessary to treat each “hospital” with a single CCN number as one hospital.

Furthermore, hospitals have a significant amount of flexibility to determine how best to organize themselves for CMS program purposes. However, once they have made their decision, there are significant administrative and financial implications associated with a hospital’s choice to enroll its facilities in the Medicare program as either individual facilities or one multi-campus hospital. For example, a hospital under a single CCN/provider number must be reviewed as an

integrated hospital for purposes of demonstrating compliance with Medicare’s Conditions of Participation (CoPs) (which also has applicability for how the hospital is certified for Medicaid); it is not permissible to separately evaluate the compliance with the CoPs of each remote location of a multi-campus hospital.

Critical Access Hospitals

In addition to incentive payments available to Medicare eligible subsection (d) hospitals that are able to demonstrate meaningful use, the statute allows Critical Access Hospitals (CAH) to receive Medicare incentive payments for the reasonable costs incurred for the purchase of certified EHR technology, excluding any depreciation and interest expenses associated with the initial acquisition. Additionally, in response to public comments on the proposed rule, CMS added CAHs to the definition of a Medicaid acute care hospital allows that CAHs will qualify for both programs.

Meaningful Use

The final rule reflects a more than yearlong effort to develop and finalize meaningful use criteria through an open and transparent process. Information was gathered from stakeholders’ through several Federal advisory committees, as well as public comments received on the proposed regulation. CMS worked closely with ONC throughout this effort and will continue to do so as the EHR incentive programs are implemented.

As CMS developed the comprehensive interpretation of “meaningful use” for the final rule, we did so with the ultimate goal of establishing consistency with applicable provisions of Medicare and Medicaid law while continually advancing the goals and objectives that certified EHR technology can help achieve. Careful consideration was given to public comments from stakeholders in the final development of this rule and where appropriate, CMS attempted to address concerns and add flexibility within the constraints of the authorizing statute. Many changes were made to better accommodate eligible professionals and hospitals by adding flexibility. The proposed rule discussed three stages of meaningful use. The final rule defines

the criteria for Stage 1 of meaningful use which applies to the first two years of the program (2011-2012). Commenters expressed concerns regarding the criteria for Stage 1 saying that the requirements in the proposed rule would be difficult to meet. In response CMS has made a number of changes designed to make the requirements more readily achievable while meeting the goals of the HITECH Act.

1. CMS stated in the proposed rule that EPs and hospitals be required to meet a set of objectives (25 for EPs and 24 for hospitals) in order to qualify as a “meaningful user” of EHR. There was significant feedback from stakeholders in their comments to make this requirement more flexible. In response, CMS added flexibility into this requirement in the final rule. EPs and hospitals will not have to meet all of the objectives in Stage 1. Instead, Stage 1 has a core set of objectives that all providers will have to satisfy. The selection of core objectives was based on the statutory requirements as their importance to laying the foundation for obtaining value from meaningful use of certified EHR. For the non-core objectives, providers will have the flexibility to defer up to five objectives, including those that are not applicable to their practice. This approach ensures that the most basic elements of meaningful EHR use will be met by all providers qualifying for incentive payments, while at the same time allowing latitude in other areas to reflect providers’ varying needs and their individual paths to full EHR use.

2. In order to achieve meaningful use, unique thresholds were set for different measures requiring the electronic exchanges of health information; all but three of these thresholds were reduced substantially in response to the comments submitted on the proposed rule. CMS decided to reduce thresholds primarily based on whether the measure was under the control of the provider and whether this standard of practice is a widely accepted standard.

For example, we reduced the threshold for e-prescribing from 75 percent to 40 percent in the final rule. We believe e-prescribing is an incredibly powerful tool in improving patient safety and increasing the efficiency of the healthcare system, but lowered the

threshold to 40 percent in the final rule in response to the strong concerns expressed by the public that 75 percent was unachievable for many eligible professionals.

3. The proposed rule included administrative transaction requirements for Stage 1. These included checking insurance eligibility and submitting claims electronically. The public commenters pointed out that that these functions are normally preformed by practice management software, as opposed to an EHR, and requiring this function be certified as part of EHRs in Stage 1 would create another barrier to adoption. In order to meet these provisions, most providers will have to upgrade their practice management systems or implement new ones. Therefore, we responded by removing these requirements for Stage 1 and strongly state our intention to include administrative transactions in Stage 2.

4. The proposed rule allowed States to submit changes to meaningful use criteria that provided for more robust requirements, but did not exceed the capability of certified EHR technology. Many commenters expressed interest in removing this flexibility, while States were heavily in favor of tailoring meaningful use to their own State-specific needs. CMS believes that it is important that States have some flexibility in implementation, so we preserved this flexibility in the final rule. However, in recognition of concerns raised, States' abilities to change Stage 1 meaningful use was limited to four public health measures. This flexibility is still subject to CMS prior approval on a State-by-State basis.

5. The proposed rule proposed that the threshold for computerized physician order entry (CPOE) be set at 80 percent for EPs and at 10 percent for eligible hospitals for all orders entered using CPOE. Commenters expressed significant concern about the ability to meet these thresholds. The final rule does include CPOE as a core objective because CMS considers this to be one of the most crucial aspects to meaningful use as it provides the opportunity for information quality, efficacy and patient safety to be presented to the provider at the point of care. To help address commenters' concerns, the final rule further clarifies the requirement and narrows its focus. The relevant measure will focus on medications ordered, and the threshold was reduced to 30 percent of medications ordered.

6. In response to the HIT Policy Committee (a Federal Advisory Committee) and public comments recommending that meaningful use should include separate objectives and measures related to patient specific education resources as well as advance directives, the final rule added both. The separate objectives and measures applies to both EPs and eligible hospitals, while the advanced directives requirement is only applicable to eligible hospitals.

Unlike under the Medicare incentives, in their first payment year, Medicaid providers may qualify for an incentive payment in if they adopt, implement, upgrade, or meaningfully use certified EHR technology. In subsequent years, Medicaid providers must demonstrate meaningful use, as described above, in order to receive EHR incentive payments.

The meaningful use definition described above for Medicare will also be the minimum requirement for the Medicaid EHR incentive program. In the Medicaid program, EPs and eligible hospitals including CAHs will have to demonstrate meaningful use and report on the required clinical quality measures to the States. Unlike the Medicare program, there are no Medicaid penalties for EPs and hospitals that are unable to demonstrate meaningful use.

Future Stages of Meaningful Use

In the proposed regulation CMS laid a path for the EHR incentive programs that proposed several stages. We also described that more specificity for future stages would be given in subsequent rulemakings. A number of the commenters requested greater detail, especially for Stage 2, scheduled to begin 2013. In response, the final regulation lays out more details about Stage 2 but does not provide specifics on Stage 3. We did not provide specifics for Stage 3 because we anticipate that we will need to take into account changes to the overall HIT infrastructure over the next several years as a result of the early stages of the EHR incentive programs. For Stage 2 we discussed in the final regulation that we would be increasing the required number of objectives, including requiring as “core” objectives all those measures that are now part of the “menu set,” and increasing required thresholds. Stage 2 will also include new functionalities which we determined are not yet ready for inclusion in Stage 1, but whose provision will be necessary to maximize the potential of EHR technology.

Clinical Quality Measures

Congress recognized the critical importance of reporting clinical quality measures (CQM) through EHRs in the HITECH legislation. CMS supports this requirement but recognizes that the infrastructure to support the electronic reporting of clinical quality measures through EHRs is not yet available. Commenters also confirmed this by asking that the electronic reporting of clinical quality measures be deferred. In the final rule, CMS has clarified that for Medicare and Medicaid providers, clinical quality measure (CQM) results must be submitted through attestation in 2011, and electronically from an EHR in 2012, provided that CMS and the States have the technology has the capacity to accept this information. In terms of the clinical quality measures themselves, CMS has tried to align reporting with other CMS quality reporting initiatives to the extent practicable, such as the CMS' Physician Quality Reporting Initiative (PQRI), Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU), and the Medicaid child and adult quality measure initiatives. In the proposed rule we proposed 90 CQMs for EPs with specific measures for specialty groups. Commenters expressed concern about including CQM measures for which there were no electronic specifications and also were concerned about the applicability of some of the core CQM to their practices. In response, CMS limited CQMs to only those which have electronic specifications. EPs will now be required to report on 3 core measures and another 3 from a set of 41 measures. Hospitals will be required to report on 15 measures as applicable to their patient population.

States' Medicaid EHR Incentive Programs

Per statute, the Medicaid part of the incentive program will be administered by States and States may choose whether they will participate. The Recovery Act provides 100 percent Federal match to States for incentive payments made to Medicaid providers for the adoption and meaningful use of certified EHRs. In addition, States will receive 90 percent Federal match for approvable expenses related to the administration and oversight of the Medicaid EHR incentive program, including the active promotion of adoption of EHR technology and health information exchange. Working closely with CMS, State Medicaid agencies will play a critical role in

enabling the success of the EHR Incentive programs. Currently, the majority of States have indicated that they expect to launch their programs during 2011.

Conclusion

The Administration has made the expansion of EHR technology a top priority. The final rule lays the groundwork for establishing a robust national health infrastructure that supports the adoption of EHRs that can help providers practice safer and more productive medicine.

CMS and ONC have worked closely together for the past 17 months as CMS has developed the policies to implement the Medicare and Medicaid EHR incentive programs. The process has been extensive and provided many opportunities for stakeholder input. We believe that the final HIT regulations capture the intent of the legislation and reflect a balance between promoting adoption and ensuring the meaningful use of EHRs. We look forward to working with our colleagues in ONC to ensure that the implementation of the EHR incentive program helps to foster an expanded use of health information technology, broadens the information exchange infrastructure and promote the adoption of electronic health records, as intended by Congress.