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3 HEARING ON ``IMPLEMENTATION OF THE HEALTH INFORMATION

4 TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH (HITECH) ACT''

5 TUESDAY, JULY 27, 2010

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The subcommittee met, pursuant to call, at 1:05 p.m., in
11 Room 2322 of the Rayburn House Office Building, Hon. Frank
12 Pallone, Jr. [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pallone, Dingell,
14 Eshoo, Green, Capps, Schakowsky, Harman, Gonzalez, Barrow,
15 Christensen, Castor, Sarbanes, Murphy of Connecticut, Space,
16 Waxman (ex officio), Shimkus, Pitts, Murphy of Pennsylvania,
17 Burgess, Blackburn, Gingrey and Barton.

18 Staff present: Ruth Katz, Chief Public Health Counsel;

19 Purvee Kempf, Counsel; Katie Campbell, Professional Staff
20 Member; Emily Gibbons, Professional Staff Member; Tim
21 Gronniger, Professional Staff Member; Virgil Miler,
22 Professional Staff Member; Alvin Banks, Special Assistant;
23 Ryan Long, Minority Counsel; Clay Alspach, Minority Counsel;
24 Sean Hayes, Minority Counsel; Brandon Clark, Minority
25 Professional Staff; and Garrett Golding, Minority Legislative
26 Analyst.

|
27 Mr. {Pallone.} I call the meeting of the Health
28 Subcommittee to order.

29 Today we are having a hearing on implementation of the
30 Health Information Technology for Economic and Clinical
31 Health Act of 2000, or the HITECH Act. Now, I should
32 mention, and Mr. Shimkus reminded me, that this is actually
33 in the Recovery Act, so we are actually talking about the
34 implementation of the HIT part, if you will, of the Recovery
35 Act. And I will recognize myself initially for an opening
36 statement.

37 The HITECH Act contained unprecedented funding to
38 promote the adoption of health information technology among
39 hospitals, doctors and health care providers through
40 initiatives by the Office of the National Coordinator of HHS
41 and through Medicare and Medicaid incentives. This historic
42 investment will serve to modernize our Nation's use of
43 technology to truly ensure a high-performing 21st century
44 system.

45 The Energy and Commerce Committee has worked on a
46 bipartisan, collaborative basis for many years on health
47 information technology. This hearing will examine the
48 progress made so far and opportunities that will be realized
49 in the future through the implementation of the HITECH Act.

50 While the United States is a leader in medical
51 technology and innovation, we have a curiously antiquated
52 system today related to health IT. Only 20 percent of
53 doctors and only 10 percent of hospitals use even basic
54 electronic health records, making coordination between health
55 care providers challenging and leaving the burden on patients
56 to ensure that each provider knows what tests have been done
57 and what medications have been prescribed. Too often, this
58 information falls through the cracks, resulting in wasteful,
59 duplicative tests and preventing providers from having the
60 full snapshot of a patient's medical profile.

61 The successful adoption of health information technology
62 will have a transformative effective on the quality of health
63 care in the United States. The provisions of the HITECH will
64 ensure that Americans nationwide have access to a truly
65 patient-centered health care system with better quality, more
66 affordable health care delivered in an efficient and
67 coordinated manner. It also will promote the advanced use of
68 electronic health records to facilitate the ordering of tests
69 and medication, aid in clinical decision-making and allow for
70 secure data-sharing and privacy protection among providers,
71 insurers and patients.

72 Now, it is timely that we have this hearing today, in my
73 opinion, since CMS just announced on July 13th the final rule

74 for the minimum requirements that eligible Medicare and
75 Medicaid providers must meet through their use of a certified
76 electronic health record technology to qualify for the
77 incentive payments included in the HITECH Act. This rule was
78 dually released with companion final regulations on the
79 standards and certification criteria needed for EHR
80 technology to be successfully used by eligible professionals
81 and hospitals.

82 There are over 2,000 health care providers, patients and
83 other stakeholders who weighed in on the proposed rule when
84 it was released in January. Many changes were incorporated
85 into the final rule, which preserved the goals of the HITECH
86 Act while also making the requirements attainable. I look
87 forward to hearing an update on these rules from our
88 witnesses today as well as on other aspects of the HITECH
89 Act.

90 I will note we have two great panels of government and
91 private witnesses here with us today. I am particularly
92 pleased that Dr. Frank Vozos, the Executive Director of my
93 hometown hospital, Monmouth Medical Center, can be with us
94 today. I had the opportunity to tour Monmouth Medical
95 Center, which is a community teaching hospital, over the, I
96 guess it was the July 4th recess or work period, and I was
97 very pleased to see the work they are doing already to

198 implement HIT adoption and to learn how they plan to use
199 HITECH funds and guidelines to further advance their medical
100 care, so I want to thank Frank Vozos, another Frank, for
101 being with us here today.

102 I have mentioned in the past sort of a personal story
103 with regard to the HIT issue. My mom passed away from
104 pancreatic cancer about 18 months ago now, and for the 7
105 months or so from when she was diagnosed until she finally
106 passed, we went to various institutions including Monmouth
107 Medical and Johns Hopkins, and it would also drive me crazy
108 because we would have, I guess it was the CAT scan put on a
109 disc--Robert Wood was another one that we visited--and at
110 each place I would try to carry the CAT scan with me and say
111 okay, here it is on a disc, you know, these are the tests she
112 had, and without reference to any particular institution, I
113 always had to have it redone, because they couldn't use,
114 either there was no interoperability or whatever. And it
115 drove me crazy but it just seemed to make no sense, and of
116 course, I was worried because she was in a bad situation,
117 that this wasn't a good thing for her to have to be retested
118 all the time. So that is just my own personal experience
119 that hopefully that type of thing we can guard against in the
120 future.

121 [The prepared statement of Mr. Pallone follows:]

122 ***** COMMITTEE INSERT *****

|
123 Mr. {Pallone.} With that, I will ask Mr. Shimkus to
124 give us an opening statement.

125 Mr. {Shimkus.} Thank you, Mr. Chairman, for holding
126 this hearing to update us on the progress of implementing the
127 HITECH Act. This issue has shared bipartisan support as we
128 seek to modernize and create efficiencies in our health care
129 delivery system.

130 Despite the enthusiasm and promises of HIT, concerns
131 have been voiced from the provider community as we move
132 forward. Some issues have already been addressed such as
133 loosening the number of requirements in the first year to
134 comply with meaningful use and allowing critical-access
135 hospitals eligibility for certain payments under Medicaid.
136 However, other roadblocks remain and we must ensure providers
137 across the country are able to meet the requirements in the
138 timeline set out.

139 The hearing today is a chance for us to review where we
140 stand and ask ourselves if we are trying to make providers
141 run before they can walk when it comes to HIT. I
142 particularly want to thank a few of our witnesses for being
143 here today from my district back in Illinois. First, Mr.
144 Gregory Starnes is here from Fayette County Hospital, which
145 is a critical-access hospital. Mr. Starnes lends a voice to

146 rural hospitals and the unique challenges they face in trying
147 to implement their systems without the budget and attention
148 of some larger urban hospitals. I also want to thank Dr.
149 Matt Winkleman from Harrisburg, Illinois, for making the trip
150 here today, and of course everyone knows Harrisburg,
151 Illinois--and that is supposed to be a joke. My staffer is
152 fired. That is a good joke. It is all in the delivery, he
153 says.

154 I look forward to hearing from Dr. Winkleman on his
155 practice was able to rise to the challenge of implementing
156 HIT while working off the small margins that come from
157 serving a rural working-class community.

158 Despite the promising future the HITECH Act holds, it is
159 difficult to look past the failures of the so-called stimulus
160 bill it was part of. The American people paid the tab on
161 what they were told would create jobs, keeping unemployment
162 at below 8 percent and to stimulate the economy. The country
163 has lost over 3 million jobs since the stimulus passed and
164 unemployment hovers at 9.5 percent, even higher in my
165 district in Illinois, all this at a cost of \$1.2 trillion to
166 the American taxpayer, an enormous failed policy continued
167 with the health reform law. We have been in session 15 weeks
168 since the health care bill was signed into law by the
169 President in March, 15 weeks and 15 hearings on health, not

170 on the law. In what is likely our last hearing before
171 recess, the majority has never responded to numerous requests
172 to hold hearings on implementation of the new law. On
173 several occasions we have asked for the Administration to
174 come before the committee, to no avail. Yet with ease we
175 were able to have representatives of both HHS and CMS to
176 discuss the HITECH Act today, and we appreciate them coming.

177 It has been over four months and the majority won't even
178 acknowledge problems exist with the new law and they aren't
179 going away. According to CBO, premiums in the individual
180 market are going to increase 10 to 13 percent as a direct
181 result of this law. Nearly all small businesses will see no
182 relief from the tax credit in the law. Many small businesses
183 will opt to pay fines rather than buy health insurance
184 because they can't afford the cost. Instead, they will raise
185 prices to customers and stop hiring new employees. High-risk
186 pools that were supposed to provide immediate coverage
187 uninsurable are going to have to waiting lines and use
188 preexisting conditions to limit those who enter the new
189 pools. We were told the President's Executive Order would
190 prevent federal dollars from being spent on abortion services
191 yet we already know in Pennsylvania and New Mexico, millions
192 of new federal dollars will go toward coverage of abortion
193 services through their high-risk pools. The President

194 promised the pro-life community and pro-life Democrats in the
195 House his executive order would prevent this from happening.
196 Will the President now make good on the promise or is this
197 evidence of what many of us feared all along, that the health
198 reform law lacks critical protections to prevent taxpayer-
199 subsidized abortions.

200 Millions of Americans will be forced into a Medicaid
201 program that is going broke. At the same time, half of all
202 seniors with Medicare Advantage will lose their coverage.
203 Those lucky enough to keep them will see increases in cost
204 while losing dental coverage and other benefits they rely on.
205 For those in traditional Medicaid, the billions of dollars in
206 cuts are unsustainable and will cause problems and reduce
207 quality of care for seniors. Leading the charge will be Dr.
208 Donald Berwick, CMS Administrator without any Congressional
209 approval, and we need to talk to the new CMS Administrator.
210 He is a big supporter of the British health system which has
211 just reported that it has failed and they were moving to a
212 decentralized process in system. The list continues to go
213 on.

214 We have a responsibility to hold hearings on the
215 implementation of the new health care law just as we are
216 doing here today when it comes to the HITECH Act. Madam
217 Chairman, with the law that will touch every American life, I

218 hope we will at least have an explanation for the majority to
219 the American people on why this request is being ignored, and
220 I yield back the balance of my time.

221 [The prepared statement of Mr. Shimkus follows:]

222 ***** COMMITTEE INSERT *****

|
223 Mrs. {Capps.} [Presiding] The Chair recognizes herself
224 for an opening statement.

225 I am so pleased that today we are exploring the
226 beginning stages of the HITECH Act and our Nation's
227 considered effort to move toward a more efficient and
228 effective system of health care. Like many of my colleagues,
229 I was here for some of the earliest conversations we had in
230 this committee about HIT and I am really proud of what we
231 have accomplished. This includes Chairman Dingell's bill
232 last Congress, the Protecting Records, Optimizing Treatment
233 and Easing Communications through Health Care Technology Act
234 of 2008, and that bill is actually the one that laid the
235 groundwork for many pieces of the HITECH Act.

236 I hope that today we will be able to explore the
237 implementation of the HITECH Act to date including both the
238 successes as well as the challenges that have been
239 encountered, but I also hope to discuss the future
240 implementation steps of this bill as our Nation's health care
241 system moves from paper-based recordkeeping to a dynamic
242 electronic system. The promise of health information
243 technology for both patients and providers is, I believe,
244 remarkable, and as the public understands how it is so
245 beneficial, it is going to make a difference in the way we

246 accept the changes in health care that will come about as we
247 see that they are very cost-effective.

248 I am a nurse by background and I am also a mother and a
249 grandmother, and I know firsthand the logistical challenge
250 that paper-based systems pose. That is one I have been
251 familiar with as a nurse most of my professional life. Every
252 parent knows how you struggle to find the proper records of
253 their child's vaccinations when they start back to school in
254 the fall. Medical specialists unsure of a senior's medical
255 regimen from their primary care provider, the senior maybe
256 can't remember all of the things that have happened since.
257 Moving to a new town, trying to fill out one's medical
258 history at the doctor for the very first time, or even when
259 you go back and you are asked to re-fill the form and you
260 can't all the things that have happened. Electronic health
261 records can follow the patient and can flag potential issues
262 while at the same time enhancing the medical provider's
263 practice by reducing inefficiencies in recordkeeping and
264 frustration in collecting an accurate medical history. And
265 while HIT is not a silver bullet to all of our health care
266 problems, it is a key step in modernizing our health system.
267 So I look forward to the testimony of our witnesses and
268 I yield back.

269 [The prepared statement of Mrs. Capps follows:]

270 ***** COMMITTEE INSERT *****

|
271 Mrs. {Capps.} At this time I will recognize Mr.
272 Gingrey for an opening statement.

273 Dr. {Gingrey.} Madam Chair, thank you so much.

274 Health information technology has the potential to
275 improve the quality and reduce the cost of health care in
276 this country. In fact, according to the Rand Corporation,
277 the potential savings for both inpatient and outpatient care
278 could average \$77 billion annually if most hospitals and
279 doctors actually adopted HIT, health information technology.
280 The study found that the largest savings would come from
281 reduced hospital stays and administrative time as well as
282 more-efficient drug utilization and not having doctors order
283 the same test two weeks apart, expensive scanning and that
284 sort of thing.

285 Therefore, Madam Chair, I am interested to hear the
286 witnesses, Mr. Blumenthal's and Mr. Trenkle's thoughts on how
287 providers will achieve the broader information exchange
288 requirements specified under stage 2 in light of the relaxed
289 requirements that the final rule has under stage 1. In
290 addition, I look forward to hearing from our second panel of
291 witnesses and their thoughts on how we move forward.

292 Madam Chair, if there were silver bullet solutions for
293 our health care system, information technology would surely

294 be one of them, maybe the main one. This technology has the
295 potential to improve the quality and the efficiency of our
296 health care system while ensuring that tax dollars are spent
297 wisely. With it, we can better identify and we can cut
298 waste, fraud and abuse out of the system. Once implemented,
299 we will be better able to protect patients' privacy and
300 eliminate the inefficiency of a system based on paper charts.
301 I know of what I speak. I practiced medicine for 31 years.

302 Therefore, a series of targeted bills based on silver
303 bullets, medical liability reform, increased transparency,
304 electronic medical records, health insurance reform for sick
305 and low-income Americans could have passed in a transparent
306 and bipartisan manner. Instead, what did we do? We passed a
307 2,400 page omnibus bill that few members could read and
308 understand. Madam Chair, I have repeatedly used my opening
309 statement in this committee over the past few months to
310 support my ranking member, John Shimkus's call for a hearing
311 on Obamacare, Patient Protection and Affordable Care Act of
312 2010? Why? Well, because on March 9th, Speaker Pelosi said
313 that the bill is, and I am going to quote her now, ``going to
314 be very, very exciting but we have to pass the bill so you
315 can find out what is in it away from the fog of
316 controversy.'' Now, that is a direct quote. Speaker Pelosi
317 was successful and this Democratic majority did pass

318 Obamacare, but the fog of controversy still exists in spite
319 of her promise. It turns out that a large majority of
320 workers won't be able to keep the health care they like today
321 and they may even lose their jobs because of the law. The
322 cost projections for patients, employers and our government
323 continue to rise. Health insurance will not be available or
324 affordable to hundreds of thousands of sick Americans. These
325 problems all represent broken promises made by the President
326 to the American people. Where the President's rhetoric has
327 not lived up to his product, Congress indeed needs to
328 investigate. The American people deserve to know what is in
329 this law, and I fear that unless we hold hearings immediately
330 to investigate the new law, our constituents will find out
331 the hard way.

332 Madam Speaker, I have gone a little bit over. Thank you
333 for your patience. I would like to submit three things for
334 the record as I yield back. One is a statement in regard to
335 electronic medical records by the American Medical
336 Association, another by the United Health Group, and finally,
337 by Electronic Health Records Association.

338 [The information follows:]

339 ***** COMMITTEE INSERT *****

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340 Mrs. {Capps.} Without objection, so ordered.

341 Dr. {Gingrey.} And I yield back. Thank you so much,

342 Madam Speaker.

343 [The prepared statement of Dr. Gingrey follows:]

344 ***** COMMITTEE INSERT *****

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345 Mrs. {Capps.} The Chair now recognizes Ms. Schakowsky
346 for 5 minutes--for 3 minutes.

347 Ms. {Schakowsky.} Thank you, Madam Speaker.

348 I just want to respond briefly to the ranking member,
349 who rather than addressing the potential for reducing costs
350 and improving care of health IT decided as usual to restate
351 the talking points of the insurance industry including saying
352 that this historic and important piece of legislation is the
353 cause of higher costs. Instead, what we have seen is
354 excessive premium increases--see Well Point--and higher
355 profits--see United Health Care, who at the same time as
356 their profits went up the amount of health care they actually
357 provide for each dollar has gone down. And a part of this
358 bill is talking about the advantages that we can reap from
359 taking advantage of health IT, which is vital for this
360 country.

361 The development of a nationwide interoperable health
362 information technology system is a critical component of
363 improving health care quality, promoting care coordination
364 and reducing medical errors. I have been in the record rooms
365 of clinics and hospitals, rooms overflowing with files taking
366 up space that could be put to significantly better use.
367 These clinics need health IT, and the \$2 billion provided in

368 the American Recovery and Reinvestment Act will go a long way
369 to upgrade and improve this Nation's health care system. As
370 someone who recognizes the substantial rewards of moving our
371 health care system toward health IT functions, I also know
372 that we must ensure complete security and privacy for
373 consumers.

374 Through the chairman's leadership, the HITECH Act
375 strengthened federal privacy and security laws to protect
376 personal identifying information from misuse. Without
377 critical privacy and security guarantees, consumers will
378 simply not be willing to utilize electronic records. As we
379 move forward with greater utilization of electronic records,
380 this is an area where we have to remain diligent.

381 I would also like to thank the witnesses today for their
382 testimony, in particular, those from the Administration.
383 Congress tasked HHS with a large job when we passed the
384 HITECH Act, and they have worked quickly to implement this
385 program. They have also been responsive, addressing concerns
386 with implementation. I was one of several members that urged
387 HHS to reevaluate their first consideration of meaningful
388 use, and they have subsequently taken many of those concerns
389 into account during rulemaking. I look forward to working in
390 the months and years ahead as we implement the full promise
391 of health IT.

392 So I thank you, Madam Chairman, and I yield back the
393 balance of my time.

394 [The prepared statement of Ms. Schakowsky follows:]

395 ***** COMMITTEE INSERT *****

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396 Mrs. {Capps.} The Chair now recognizes Mr. Pitts for
397 his opening statement.

398 Mr. {Pitts.} Thank you, Madam Chairman.

399 On February 17, 2009, the President signed the American
400 Recovery and Reinvestment Act, also known as the stimulus
401 bill, into law, promising that the \$787 billion bill would
402 create or save 3-1/2 million jobs over the next 2 years. We
403 were also told that the stimulus would hold unemployment
404 under 8 percent. At this point in the recovery, unemployment
405 would be at 7.5 percent. No one, not the White House, not
406 Congressional leadership, can tell us with any degree of
407 accuracy how many jobs have been saved or created. In fact,
408 it is impossible to calculate how many jobs were not lost due
409 to the passage of the stimulus or any other bill, for that
410 matter. As for jobs created, we have an ever-expanding
411 federal workforce, not a thriving private sector, and as we
412 all know, unemployment is currently at 9.5 percent after
413 peaking at 9.9 percent earlier this year.

414 One of the provisions included in the stimulus was the
415 Health Information Technology for Economic and Clinical
416 Health, or HITECH Act. While I would question how the HITECH
417 Act is stimulative or how many jobs it has saved or created,
418 we all see the promise of health information technology from

419 reduced errors, greater efficiencies to being able to share
420 information across the country with the click of a mouse, and
421 I support the goals of the HITECH Act. Many of us have been
422 contacted, however, by providers from back home who panicked
423 when the proposed rule came out earlier this year, and it
424 seemed that few hospitals and doctors' offices could meet
425 such an aggressive implementation timetable or stringent
426 criteria.

427 I hope that our Administration witnesses will discuss
428 how the final rule has been changed to address some of these
429 concerns, and I look forward to hearing from our witnesses.

430 Thank you, Madam Chairman. I yield back.

431 [The prepared statement of Mr. Pitts follows:]

432 ***** COMMITTEE INSERT *****

|
433 Mrs. {Capps.} The Chair now recognizes Ms. Eshoo for
434 her opening statement.

435 Ms. {Eshoo.} Thank you, Madam Chairwoman. It is nice
436 to see you in the chair, and thank you for holding this
437 important hearing on the implementation of the HITECH Act.

438 The legislation we included in the American Recovery and
439 Reinvestment Act to promote health information technology was
440 adopted to revolutionize the health care delivery system in
441 our country. I have been so often struck by this: we live
442 in the Information Age and yet our health care system has
443 really been mired in the pen-and-paper past, and so the money
444 that is directed toward a comprehensive, interoperable and
445 nationwide HIT system is one that really meets what the 21st
446 century is all about, and I don't think that there is a doubt
447 that this will have a salutary outcome in terms of enhancing
448 patient safety, reducing medical errors, improving the
449 overall quality of care, and of course, having a system that
450 protects the privacy of patients as well.

451 I have been concerned for a long time about this issue.
452 I introduced comprehensive legislation, HIT legislation, in
453 2007. We spent months meeting with doctors, with hospitals,
454 with technology companies, which I think everyone knows, many
455 of them make their home in my Congressional district, as well

456 as HIT vendors, and I am proud to say that the work that my
457 staff and myself did on that legislation really became the
458 basis of the legislation that Mr. Dingell introduced and now
459 we are going to be reviewing it.

460 So I am really pleased that Dr. Blumenthal, the National
461 Coordinator for HIT, and Anthony Trenkle from the Office of
462 E-Health at CMS are going to share with us their experiences
463 in implementing the legislation. I know that there are bumps
464 in the road. There always are. When constituents ask me
465 about legislation, I always say well, understand that
466 legislation is shaped by human beings and that legislation
467 bears the mark of humanity. It is less than perfect. But
468 what is exciting to me is that we have launched the effort.
469 We have placed significant resources next to it, \$2 billion,
470 and so today is a good chance to hear about how we are doing
471 on this very important journey. So I look forward to hearing
472 from our friends that are here to be witnesses and also to
473 the second panel that will instruct us as well.

474 So I thank the chairwoman, I thank the chairman of the
475 subcommittee for scheduling this and I thank the witnesses
476 and look forward to hearing from you.

477 [The prepared statement of Ms. Eshoo follows:]

478 ***** COMMITTEE INSERT *****

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479 Mrs. {Capps.} I thank my colleague.

480 Now we turn to the ranking member of the full committee,
481 Mr. Barton, for his opening statement.

482 Mr. {Barton.} Thank you, Madam Chairwoman. I thank you
483 and Ranking Member Shimkus and Subcommittee Chairman Mr.
484 Pallone for holding this hearing. We thank our witnesses on
485 this panel, and I know we have several on the second panel.
486 We thank them for participating, especially the witness from
487 the Heart of Texas Community Health Center down in Texas. We
488 are glad that he is here.

489 Obviously the Republicans are not against health
490 information technology. Last year we worked on a bipartisan
491 basis to pass a bipartisan health IT bill. Unfortunately,
492 that bill did not become law. Instead, at the start of this
493 Congress, our friends in the majority passed their version of
494 health IT as part of the so-called stimulus bill. I would
495 like to hear from the witnesses later this afternoon just how
496 stimulative that has been. The unemployment rate is about 9-
497 1/2 percent around the country. This bill that we are
498 looking at today didn't do much in the private sector. It
499 focused more on spending federal dollars while ignoring the
500 less-expensive avenues for health IT deployment. I think it
501 would have been better to allow hospitals and physicians to

502 donate health IT systems to each other, for example. It has
503 been over a year since this bill became law, the stimulus
504 bill, that is. That package is going to cost about \$1-1/2
505 trillion. Numbers that I have been given indicate that
506 according to the Bureau of Labor Statistics, we have lost
507 over 3 million jobs in that time, so I think it is a fair
508 question: where are these jobs and how has this particular
509 bill helped create jobs.

510 While it is not the focus of the hearing, last week
511 myself and several other Republicans asked for a hearing on
512 the recess appointment of Dr. Berwick to head the new CMS.
513 Dr. Berwick was appointed without being approved by the
514 Senate, which I think is a bad precedent, although not
515 unprecedented. Obviously other Presidents have done recess
516 appointments. As we try to implement the new health care
517 law, the bigger law, I think people have a right to know how
518 Dr. Berwick plans to implement that law and make all those
519 cuts in Medicare in the neighborhood of \$145 billion.

520 So in any event, Madam Chairman, again, we are not
521 opposed to health IT, we are not opposed to the federal
522 government being involved, but we didn't have much say in
523 this particular bill, so it is going to be an interesting
524 dialog as we go forward.

525 With that, I will put the rest of my statement in the

526 record. And again, we do thank our witnesses and we look
527 forward to their testimony. Thank you.

528 [The prepared statement of Mr. Barton follows:]

529 ***** COMMITTEE INSERT *****

|
530 Mrs. {Capps.} Thank you, Mr. Barton.

531 And now we turn to Ms. Christensen for her opening
532 statement.

533 Dr. {Christensen.} Thank you, Madam Chair, and I want
534 to thank you and Chairman Pallone and the ranking member for
535 holding this hearing on implementing of HIT, an issue that
536 has been of particular importance for me. Of course, it is
537 important to all providers, but providers of color, those in
538 minority and poor and rural neighborhoods in my district have
539 a particular interest in how it is going to be implemented.

540 The Health Information Technology for Economic and
541 Clinical Health Act holds out great promise for improving
542 medical care, and although a few would disagree, reducing
543 health care costs in the future. But I also want to make
544 sure that it eliminates disparities, not exacerbate them. I
545 appreciate the response of the public comments on what
546 constitutes meaningful use, but if some of the big guys like
547 Partners in Health Care, Kaiser Permanente and others have
548 concerns about being able to meet the standards, certainly
549 the smaller, poorer, understaffed, overworked providers will
550 definitely have problems. I can imagine that OMC has in
551 balancing the need to get this implemented, ensuring privacy
552 and bringing all providers in. On the other hand, I know the

553 challenge of providers like I was would have getting this
554 implemented while trying to take care of patients. We will
555 looking to the regional extension centers like the one at the
556 University of Ponce in Puerto Rico with the Virgin Islands
557 Medical Institute for their help in getting this done. Dr.
558 Blumenthal, in your testimony you say that we should look at
559 this not as investments in technology per se but as efforts
560 to improve the health of Americans and the performance of
561 their health care system, and of course key to improving the
562 health of all Americans is to ensure that those who are
563 disproportionately affected by health inequities are able to
564 access and take full advantage of the provisions of the
565 HITECH Act.

566 So I look forward to the testimony and thank and welcome
567 our witnesses for being here today.

568 [The prepared statement of Dr. Christensen follows:]

569 ***** COMMITTEE INSERT *****

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570 Mrs. {Capps.} The Chair now recognizes Mr. Burgess for
571 an opening statement.

572 Dr. {Burgess.} I thank the Chair for the recognition.
573 Welcome to our witnesses. We are grateful that you are here.
574 I am grateful that our committee is exercising proper
575 oversight to see if the HITECH provisions of the stimulus
576 bill are being implemented as intended. After all, the
577 United States Congress put \$20 billion on the table with the
578 goal of increasing and ultimately achieving universal
579 electronic medical record adoption.

580 For the record, I did not support the stimulus bill and
581 I continue to believe that some of the provisions relating to
582 health information technology contained within that bill have
583 actually been inhibitory toward their adoption. I am still
584 uncertain whether providing financial incentives such as
585 grants will be effective. I continue to believe that claims-
586 based incentives ultimately make more business sense.

587 In addition, our lack of addressing safe-harbor issues
588 is a flaw, and early in an early iteration of a health IT
589 bill, H.R. 1031, I introduced such a concept but
590 unfortunately it was not part of the language that was
591 adopted by the majority when the stimulus bill was passed. I
592 would also like to be certain that new federal guidelines are

593 working in coordination with the quality improvement
594 initiatives that many in the industry are already undertaking
595 and certainly not work at cross purposes to those efforts.

596 We need to focus on implementation. Even if I didn't
597 agree on how, I am committed to ensuring that the taxpayer
598 dollars are now used responsibly to establish the goal that
599 was set forth. Even if \$1 doesn't go out the door, penalties
600 for providers are coming no matter what, and guess what?
601 They are coming pretty darn fast. They will be here in just
602 a couple of years. I have been committed to see that the
603 rules set up by the federal government encourage adoption and
604 allow providers to avoid the proverbial sword of Damocles
605 hanging over the head of every doctor and every hospital in
606 the country in just a few short years. I have certainly been
607 fearful that federal regulations might bog down the normal
608 and routine medical treatment by requirements that are
609 unnecessary and that I imagine both patients and doctors will
610 have some difficulty with complying. Unfortunately, the
611 draft regulations put out in February were, in a word,
612 unworkable. I authorized with representatives Space, Stearns
613 and Engel a letter pointing out several issues with the
614 proposed rule. These were so intuitively obvious that 250
615 Members of Congress agreed to sign on to the letter. Dr.
616 Blumenthal, to his credit, has always taken my calls, always

617 listened to my concerns and did address many of the issues
618 that were raised. I do remain concerned about the multi-
619 campus issue which has been mentioned and on certification of
620 existing systems as qualified to receive incentive payments,
621 and Madam Chairwoman, I would like to insert into the record
622 a statement by the Premier Health Care Alliance addressing
623 that issue.

624 So we will continue to work in Congress on legislation
625 to address these issues as they come up. We hope we can
626 achieve a bipartisan consensus with our members in this
627 committee on both sides of the dais and with committee
628 members of Ways and Means. I certainly look forward to
629 hearing the testimony today and I will yield back the balance
630 of my time.

631 [The prepared statement of Dr. Burgess follows:]

632 ***** COMMITTEE INSERT *****

|
633 Mrs. {Capps.} Hearing no objection, the Chair will
634 insert the letter that is recommended by the gentleman.
635 [The information follows:]

636 ***** COMMITTEE INSERT *****

|
637 Mrs. {Capps.} And now turning to Mr. Sarbanes for an
638 opening statement.

639 Mr. {Sarbanes.} Thank you, Madam Chair. I look forward
640 to the testimony from the witnesses today.

641 The search for the tipping point on health information
642 technology has sort of been for some like the search for the
643 Holy Grail. I don't think when we get there that is what it
644 will turn out to be but I do think it is going to make a huge
645 difference, first for patients and then for the costs of the
646 system in terms of reducing cost, promoting more efficiency
647 and so forth.

648 I always have every head in the room nod when I talk to
649 an audience about how frustrating it is when a patient goes
650 to a provider and has to have the baseline medical record
651 recreated for them because it is so difficult for the
652 provider to put their hands on tests and other records that
653 have been done and are available out there somewhere but they
654 somehow can't get hold of those, the result being that the
655 patient is then subjected to more tests, more pushing and
656 prodding when that information that we give the provider a
657 baseline picture of the person's health and condition is
658 available, it is just not at their fingertips. And HIT has
659 the potential to solve that problem. When it does so, it is

660 going to make a tremendous advance forward for patient care
661 and obviously, as I said, improve efficiency and reduce cost.

662 So I think the investment in this both in the stimulus
663 bill and in the health reform law was a smart investment. I
664 am looking forward to hearing from you today as to how we are
665 making progress on that investment, and I yield back my time.
666 Thank you.

667 [The prepared statement of Mr. Sarbanes follows:]

668 ***** COMMITTEE INSERT *****

|
669 Mrs. {Capps.} The Chair now recognizes Ms. Blackburn.

670 Mrs. {Blackburn.} Thank you, Madam Chairman, and we do
671 welcome our guests and we thank you for being here.

672 We do want to keep tabs on what is happening with the
673 HITECH Act, with health IT as it moves forward. We are
674 concerned about the funds that were provided in the stimulus
675 bill, what was included there and we are also concerned with
676 the rules. I am glad that CMS has finally published the
677 final rules for the electronic health records and we know
678 that our doctors and our hospitals are working diligently to
679 try to comply with these rules because we are hearing from
680 them, and while we know that the EHRs are going to hold
681 tremendous promise, we also know that we have got some
682 hurdles out there if we are going to reach the goal of
683 everyone having an electronic health record by 2015.

684 I think that everyone is concerned with this deadline of
685 January 1, 2011. We will have some questions about that
686 because that is the time for provides to have in place a
687 certified EHR to qualify for those Medicare health IT
688 incentive programs, and between now and then our providers
689 and vendors are going to have to ramp up very quickly. I
690 will say, Madam Chairman, I think that when Congress does not
691 engage in putting some of these items in statute and leaves

692 it to agencies to put in place, we see unworkability and
693 having to do some revisits. It also appears that CMS had
694 lowered the bar in some areas in the recent rule while
695 remaining overly prescriptive in others. An example,
696 Tennessee hospitals are extremely concerned about the
697 financial implications on multi-campus hospitals that share a
698 single Medicare provider number. That is another area we
699 will want to discuss with you today.

700 What we must keep in mind that government excels at
701 regulation, not innovation, and we are going to need to
702 listen to the private sector on this and we will look forward
703 to some questions there for our second panel, and as this
704 rush is taking place to build this nationwide network very
705 quickly, I am concerned that CMS could end up building a
706 national but suboptimal system, and I hope that we are going
707 to continue to see working through these problems together.

708 Tennessee is a leader in the health IT innovation and
709 implementation and we are hopeful that this can be put on the
710 right direction and some of these concerns and stumbling
711 blocks addressed as we move along the way.

712 I thank you for the time. I yield back.

713 [The prepared statement of Mrs. Blackburn follows:]

714 ***** COMMITTEE INSERT *****

|
715 Mrs. {Capps.} The Chair is now pleased to recognize the
716 chairman emeritus of the full committee, Mr. Dingell, for his
717 opening remarks.

718 Mr. {Dingell.} Madam Chairman, thank you, and thank you
719 for holding this important hearing.

720 Health information technology has the ability to
721 modernize and improve our entire health care system by
722 allowing for more informed decision-making, by reducing
723 duplicative and unnecessary paperwork, by speeding up
724 diagnoses and by reducing medical errors. The Health
725 Information Technology for Economic and Clinical Health Act,
726 HITECH, that was passed as a part of the American Recovery
727 and Reinvestment Act of 2009, created an unprecedented
728 investment in health information technology. In fact, the
729 Congressional Budget Office noted the adoption of health IT
730 would reduce Medicare spending by \$4.4 billion over the 2011-
731 2019 period and create federal savings in Medicaid over \$7
732 billion in the same timeframe. Given this potential, we must
733 ensure that we get a good return on that investment and
734 vigorously move forward on the implementation of the statute.

735 These resources will put us on the path to a more
736 coordinated health care system, which is why the topic of
737 health information technology has long been a focus of this

738 committee. I would like to note that not only has this
739 committee spent many years studying and legislating on the
740 matter but that we have done so in a bipartisan fashion. For
741 example, in the last Congress, this committee passed the
742 bipartisan health information technology bill, H.R. 6357, the
743 Protecting Records, Optimizing Treatment and Easing
744 Communication through Health Care Technology Act of 2008.
745 This bill included language to codify the Office of National
746 Coordinator for Health IT and to provide grants designed to
747 stimulate the spread of HIT. It also included strong privacy
748 protections. This bill became the basis for the HITECH Act.'

749 The Administration recently issued rules, final in
750 character, to support meaningful use of electronic health
751 records. I am delighted that the Office of National
752 Coordination for Health IT and Centers for Medicare and
753 Medicaid Service have worked with all interested parties to
754 develop standards that are attainable but also propel our
755 health technology systems forward. They have had to thread a
756 very fine needle, and overall they have done a commendable
757 job. However, we all understand that a few concerns remain.
758 I am confident the Administration will continue to hear and
759 respond to the legitimate concerns. I am also aware that the
760 work of the Congress may not be totally done on this issue.

761 I want to thank both of the panels of our witnesses

762 today for joining us and look forward to their updates on the
763 implementation process. We will find that the testimony
764 today will be in front of a group of people that has a real
765 interest in ensuring that HITECH Act moves forward in a way
766 that fulfills the intent of the legislation.

767 Again, Madam Chairman, I thank you and I yield back the
768 balance of my time.

769 [The prepared statement of Mr. Dingell follows:]

770 ***** COMMITTEE INSERT *****

|
771 Mrs. {Capps.} The Chair is pleased to recognize for an
772 opening statement Ms. Castor.

773 Ms. {Castor.} Thank you, Madam Chair, for calling this
774 hearing on how we improve health care through modern
775 technology. You know, the health care investments that have
776 been made through the Recovery Act have really been a godsend
777 to communities all across the country and created thousands
778 and thousands of jobs including in my hometown of Tampa and
779 the Tampa Bay area.

780 One of the initiatives that I am most proud of was made
781 possible by the HITECH Act included in the Recovery Act and
782 it is the Paper-Free Florida Collaborative Regional Extension
783 Center. In April, Paper-Free Florida was awarded nearly \$6
784 million for its initiative developed by the University of
785 South Florida in my district. It is one of more than 70
786 regional extension centers authorized by the Office of
787 National Coordinator. I notice that Glen Tullman from
788 Allscripts is here. He gave us great advice and
789 encouragement from the get-go, so I am glad you are here,
790 Glen. Paper-Free Florida will effectively implement
791 electronic health records in more than 1,000 priority
792 clinical practices, and I heard from the other side of the
793 aisle where are the jobs. Well, I am grateful that a number

794 of the jobs are right in my hometown in Tampa because what we
795 are going to be able to do is recruit and train and employ
796 over 100 e-health ambassadors as HIT extension agents in 20
797 countries. We are going to avoid costly medical errors for
798 patients, and you should have seen the young doctors when we
799 made the announcement. They are already there. They know
800 this technology and they just can't wait to get started, and
801 it is exactly what we intended by the Recovery Act, creating
802 these high-wage jobs that communities like mine need in this
803 economic downturn. So thank you.

804 While I am proud that one of the many success stories
805 made possible by the HITECH Act comes from my community,
806 there are a few roadblocks that we need to address to ensure
807 that more health care providers are able to coordinate care,
808 and one area of improvement I think I am hearing consensus
809 across the board here is the meaningful-use rules, and I
810 think you for granting additional flexibility as you took
811 comments from folks and providers all across the country, but
812 we have more work to do here. Dr. Blumenthal, you have
813 worked hard to make sure that certain entities that are
814 eligible for HIT incentive payments are going to be eligible,
815 but as many of the members today mentioned, the hospital
816 systems with multiple campuses remain in a tough spot under
817 these new rules. And I was with a chief medical officer in

818 Florida for a big hospital system yesterday, they were
819 singing your praises, but this is giving them real heartburn.
820 The decision to allow only one payment per provider number,
821 even if that provider number is used for more than one
822 facility, puts multi-campus hospitals at a real disadvantage.
823 Meanwhile, they have great potential to deliver results, the
824 results that we need.

825 Nevertheless, the overall benefit of the HITECH Act is
826 among the most exciting components of the Recovery Act and
827 alongside the Affordable Care Act, we will continue to make
828 great strides to improve the health for American families.

829 So thank you, Madam Chairman, and I look forward to
830 hearing from our witnesses today. I yield back.

831 [The prepared statement of Ms. Castor follows:]

832 ***** COMMITTEE INSERT *****

|
833 Mrs. {Capps.} The next opening statement will be by Mr.
834 Green.

835 Mr. {Green.} Thank you, Madam Chairman. Before I begin
836 I would like to ask unanimous consent to include a written
837 statement for the record. This is written testimony of Dan
838 Hawkins of the National Association of Community Health
839 Centers.

840 Mrs. {Capps.} Hearing no objection, so ordered.

841 [The information follows:]

842 ***** COMMITTEE INSERT *****

|

843 Mr. {Green.} Like my colleagues, I thank you for
844 holding this hearing to check on the implementation and
845 progress of the Health Information Technology for Economic
846 and Clinical Health Act of 2009. For many years, this
847 committee and Congress has the goal of encouraging large-
848 scale implementation of electronic health records. The
849 passage of the Health Information Technology for Economic and
850 Clinical Health Act of 2009, HITECH, in the American Recovery
851 and Reinvestment Act of 2009 demonstrated Congress's
852 commitment to improving and coordinating patient care as well
853 as streamlining and updating our medical records system. In
854 a high-tech world, the days of paper records should be well
855 behind us.

856 With integrated information technology, patients can
857 manage their own electronic records and avoid having to haul
858 multiple records to various physicians. The lack of
859 coordinated care in the country is startling, but if we can
860 coordinate our care systems through health IT, we have a
861 potential to change our health care system.

862 We are all aware of the benefits improved IT will bring
863 the health care sector and the patients it serves. If
864 implemented correctly, health IT will improve patient safety
865 and garner cost savings. That is why I am glad we are having

866 the hearing today to discuss the status and the
867 implementation of the HITECH Act. As we know, no legislation
868 is perfect and Congress has a history of revisiting
869 legislation many years after its passage. The HITECH Act is
870 no exception. I am particularly interested in discussing
871 potential changes that need to be made to assist community
872 health centers and mental health providers adopt health IT.

873 The implementation of health IT has dramatically
874 improved the community health center coordination of care in
875 our district and we are excited about the potential this has
876 to improve quality of health care for medically underserved
877 in the district. I do want to discuss how payments to health
878 care IT are made to individual providers at the community
879 health centers rather than the actual health center, which is
880 a more common practice in allowing recurrent funding for
881 health centers.

882 With regard to mental health providers, I sponsored the
883 Community Mental Health Services Improvement Act for many
884 years. This legislation contains funding for the
885 establishment of grant programs to improve health IT for
886 mental health providers. I recently began working with
887 Representative Patrick Kennedy and Representative Tim Murphy
888 on H.R. 5040, the Health Information Technology Extension for
889 Behavioral Health Services Act, which would amend HITECH to

890 give mental health providers, substance-abuse providers and
891 psychiatric hospitals in parity with other health care
892 providers for medical use of health information technology
893 and electronic health. This legislation clarifies the
894 definition of health care provider to include mental health
895 professionals, substance-abuse professionals, psychiatric
896 hospitals, behavioral mental health clinic and substance-
897 abuse treatment facilities. The legislation requires HHS
898 through the National Coordination of Health Insurance
899 Technology to award grants for mental health treatment
900 facilities not eligible for meaningful-use incentives through
901 the HITECH Act. The grants would allow for purchase of
902 certified electronic records training of medical staff and
903 the use of electronic records and improve the exchange of
904 health information between mental health providers and other
905 health care providers. I am hopeful these issues can be
906 discussed in the future the community health centers and
907 mental health providers are an integral part of our health
908 care system.

909 Again, I want to thank the witnesses for appearing. I
910 want to welcome Dr. Roland Goertz, CEO and Executive Director
911 of Heart of Texas Community Health Center in Waco on the
912 second panel, and I yield back my time.

913 [The prepared statement of Mr. Green follows:]

914 ***** COMMITTEE INSERT *****

|
915 Mrs. {Capps.} Thank you.

916 Mr. Murphy is now recognized for his opening statement.

917 Mr. {Murphy of Pennsylvania.} Thank you, Madam
918 Chairman.

919 We all know that electronic medical records hold
920 enormous potential for the practice of medicine but tools
921 like IT with health are only valuable if we know how to use
922 them and if we have them, and that process began with more
923 than \$20 billion in federal resources allocated. Today, only
924 6 percent of hospitals and 2 percent of physicians rely on
925 these health records.

926 These incentives no doubt are going to increase
927 participation but as I have heard from many doctors and
928 hospitals in my district, that initial requirement for
929 incentive payments seems to be too complex and unobtainable.
930 Now with CMS cutting back on the scope of HIT mandates, it
931 has given providers more time to adopt records that will
932 collect essential patient data, and I look forward to hearing
933 what providers can do before being financially penalized for
934 noncompliance.

935 HIT will be an essential component of medicine, or as
936 Dr. David Blumenthal has put it aptly, as accepted in the
937 daily lives of health professionals as the stethoscope and

938 the exam table. Well said. Health IT is most valuable when
939 it is available to providers across all disciplines, and as
940 it advances, we want to make sure government is not a barrier
941 but a team member to work better, effectively, efficiently
942 and economically.

943 I also believe that health IT needs to be integrated,
944 interactive, interoperable and intelligent in order to
945 provide great patient outcomes, and that is where I am afraid
946 sometimes we may fall short in terms of integrating care, and
947 let me give two quick examples. Patients in skilled nursing
948 homes are extremely ill on average and take eight different
949 kinds of medication. Eighty percent of this population comes
950 from a hospital, but there is little exchange of patient data
951 electronically, so a hospital may discharge a patient to a
952 skilled nursing facility on Friday, the paper records are
953 sent to the skilled nursing facility via fax a day or two
954 later. If it was electronic, that facility could do a better
955 assessment upon admittance and know the patient's medications
956 immediately.

957 Second, we need to be thinking about the overall health
958 of an individual. Unfortunately, the incentives exclude
959 mental health providers. As my colleague, Mr. Green, said,
960 Congressman Patrick Kennedy and I have put in a bill, the
961 HITECH Extension for Behavioral Health Services, H.R. 5040,

962 to make mental health providers eligible for the federal
963 incentive payments. This is a critical bill, and it would
964 extend Medicare and Medicaid reimbursements for meaningful
965 use of electronic health records to mental health
966 professionals across a spectrum.

967 So as Congress continues to support advances in
968 technology, I look forward to working with this committee to
969 secure passage of this bill and others. Keep in mind that
970 those with chronic illness run the risk twice that of the
971 population for having depression and other mental illnesses.
972 We have to make sure that all these records are integrated
973 together so that whatever medical problem they have, whatever
974 complications people with chronic illness have, the key
975 feature of electronic medical records is to make sure we can
976 use them and provide the incentives and provide the
977 facilities for us to be able to make better medical
978 decisions.

979 With that, I yield back.

980 [The prepared statement of Mr. Murphy of Pennsylvania
981 follows:]

982 ***** COMMITTEE INSERT *****

|
983 Mrs. {Capps.} Thank you, Mr. Murphy.

984 Mr. Space, you are now recognized for your opening
985 statement.

986 Mr. {Space.} Thank you, Madam Chairman.

987 Thank you for holding the hearing on an issue that of
988 considerable important to all of us. When it comes to health
989 IT, there does seem to be a great deal of agreement on both
990 sides of the aisle with very good cause. Both Democrats and
991 Republicans, providers and consumer groups by and large seem
992 to agree that improving the adoption of health information
993 technology around the country will be beneficial to the
994 practice of medicine, reduce redundancies, save money,
995 provide a safer environment for patients and certainly in
996 include myself in this support. How we achieve the adequate
997 adoption of health IT is what has brought us here today.
998 Ensuring that every hospital, doctor and clinic in this
999 country have high-quality record systems that ensure patient
1000 safety is not an easy task and there is no simple answer to
1001 how we reach that destination.

1002 The HITECH Act included as part of H.R. 1 earlier this
1003 year offers a promising framework for accomplishing this
1004 goal, establishing an Office of the National Coordinator and
1005 developing a structure for incentive payments has created a

1006 framework for pushing the adoption of health IT in a
1007 strategic and meaningful way. However, the meaningful-use
1008 rule provided by CMS 2 weeks ago holds some troubling
1009 provisions that I fear may steer us away from adoption, and I
1010 would like to touch on two of those issues today, first, the
1011 multi-campus issue that was brought up earlier I think during
1012 Mr. Burgess's statement. I believe firmly that it was the
1013 intent of this body in passing the HITECH Act to ensure that
1014 each hospital would be entitled to its own incentive
1015 payments. The rule offered by CMS denies those payments to
1016 hospitals that have chosen to structure themselves with
1017 multiple campuses under a single provider number, and I am
1018 disappointed in this decision, particularly after we worked
1019 with Representatives Burgess, Engel and Stearns to send a
1020 letter to CMS that was signed by 240 members of this body.
1021 My staff will continue to work with those members and their
1022 staffs along with the staff of this committee and the Ways
1023 and Mean Committee so that this issue can be resolved.

1024 And the second concern we have is what this rule will
1025 mean for smaller rural hospitals like the 13 that we have in
1026 Ohio's 18th Congressional district. Most of those hospitals,
1027 indeed, all of those hospitals, see an exceptionally high
1028 caseload of Medicare and Medicaid recipients with an ever-
1029 growing number of self-pay cases. That is a euphemistic term

1030 for charitable cases. We see these cases increasing with the
1031 economy. For these hospitals, investing in the needed
1032 capital to purchase health IT systems that meet the criteria
1033 spelled out today is especially challenging. Even with the
1034 promise of incentive payments, these investments are costly
1035 and difficult. I still have concerns about what these
1036 requirements will mean for our hospitals and I certainly hope
1037 to learn more about how HHS and CMS intend to help small
1038 rural hospitals in accessing this vital technology.

1039 Thank you, Madam Chair.

1040 [The prepared statement of Mr. Space follows:]

1041 ***** COMMITTEE INSERT *****

|
1042 Mrs. {Capps.} Thank you.

1043 The Chair recognizes Mr. Barrow for an opening
1044 statement.

1045 Mr. {Barrow.} I thank the Chair for the opportunity to
1046 explore this topic.

1047 In getting ready for this hearing, I reached out to some
1048 of the folks on the ground back in my district and some of
1049 the folks who represent them up here, and there still seem to
1050 be a lot of unknowns and unanswered questions out there. We
1051 spent a lot of time poring over legislative language and
1052 debating the definitions of legislative terminology. I would
1053 like to bring to the attention of the committee some of the
1054 more fundamental challenges that I am talking about.

1055 I represent areas that don't even have access to
1056 reliable broadband services. I represent counties that are
1057 at least an hour's drive away from the nearest IT
1058 professional. I am concerned that even if we do everything
1059 right up here, we make grant funding available, we offer
1060 technical guidance, we provide reasonable rewards for proper
1061 implementation, many providers out there are still going to
1062 be left behind because we still don't have the proper
1063 technological infrastructure in place to take full advantage
1064 of this. So my concern is that we make great leaps forward

1065 in all other kinds of place with information technology that
1066 we don't forget those folks who are still struggling to get
1067 on board the IT bandwagon in the first place, and I hope that
1068 can be addressed in the course of the hearing.

1069 Thank you, Madam Chair, and I yield back the balance of
1070 my time.

1071 [The prepared statement of Mr. Barrow follows:]

1072 ***** COMMITTEE INSERT *****

|
1073 Mrs. {Capps.} Ms. Harman, the Chair recognizes you for
1074 an opening statement.

1075 Ms. {Harman.} Thank you, Madam Chair. It is nice to
1076 have a school nurse in the chair, and the quality of school
1077 nursing care matters to this committee, and I think
1078 electronic IT will be helpful even at that level, and I am
1079 sure you agree with me.

1080 Mrs. {Capps.} Absolutely.

1081 Ms. {Harman.} Most of our colleagues have described
1082 what it is in this legislation, which is absolutely essential.
1083 I just wanted to add a couple of things that haven't been
1084 said. One is that a firm in my district makes dog tags,
1085 electronic health dog tags for soldiers, and has had some
1086 success in selling these to the Pentagon. I have no idea,
1087 and probably others would know better than I, whether these
1088 could have a civilian application, but the notion that a
1089 soldier hit on the battlefield would have all of his health
1090 records in this tiny little chip that he wears around his
1091 neck is an exciting idea and it might really be useful to
1092 people who for any number of reasons could get into problems
1093 and urgently need one health provider to be able to download
1094 their history. There would obviously be some notion of
1095 choice here. I don't assume everyone would be compelled to

1096 wear these things, but I just put it out there as something
1097 that I think may have promise.

1098 The other thing I would want to mention that has been
1099 said, I am sure, before but not while I have been sitting
1100 here is the issue of both privacy and accuracy of records. I
1101 mean, once we consolidate and integrate health data, and boy,
1102 do I think ``integration'' is a critical word, it has to be
1103 accurate. The goal here is obviously to reduce errors and
1104 duplication, but what is on those records really matters and
1105 so while our legislation goes a long way in that direction, I
1106 just mention to our witnesses that this is something that
1107 will need renewed focus.

1108 And I congratulate this committee for legislating on a
1109 bipartisan basis in an area that is absolutely critical to
1110 the quality and cost of health care for Americans including
1111 school kids who go to excellent school nurses like our friend
1112 Lois.

1113 Thank you very much. I yield back, Madam Chair.

1114 [The prepared statement of Ms. Harman follows:]

1115 ***** COMMITTEE INSERT *****

|
1116 Mrs. {Capps.} And on that note, we conclude our opening
1117 statements by members of the subcommittee and we turn now to
1118 our witnesses. I want to welcome you both and thank you for
1119 your patience in listening to all of us. We have on our
1120 first panel Dr. David Blumenthal, National Coordinator of
1121 Health Information Technology for the U.S. Department of
1122 Health and Services, also joined by Mr. Anthony Trenkle,
1123 Director of the Office of E-Health Standards and Services,
1124 Centers for Medicare and Medicaid Services. Welcome to you
1125 both.

1126 Dr. Blumenthal, you may begin your testimony.

|
1127 ^STATEMENTS OF DAVID BLUMENTHAL, M.D., NATIONAL COORDINATOR,
1128 HEALTH INFORMATION TECHNOLOGY, U.S. DEPARTMENT OF HEALTH AND
1129 HUMAN SERVICES; AND ANTHONY TRENKLE, DIRECTOR, OFFICE OF E-
1130 HEALTH STANDARD AND SERVICES, CENTERS FOR MEDICARE AND
1131 MEDICAID

|
1132 ^STATEMENT OF DAVID BLUMENTHAL

1133 } Dr. {Blumenthal.} Chairwoman Capps, Ranking Member
1134 Shimkus, distinguished subcommittee members, thank you for
1135 the opportunity to submit testimony on behalf of the
1136 Department of Health and Human Services regarding the
1137 implementation of the Health Information Technology for
1138 Economic and Clinical Health Act.

1139 The provisions of the HITECH Act are best understood not
1140 as investments in technology per se but as efforts to improve
1141 the health of Americans and the performance of their health
1142 care system. Three interdependent rulemakings were required
1143 to implement the provisions of the HITECH Act generally and
1144 the Medicare and Medicaid EHR incentive programs in
1145 particular. The first rulemaking establishes the
1146 requirements that eligible health care providers will need to
1147 satisfy in order to qualify for incentive payments. The

1148 second specifies the technical capabilities and standards
1149 that certified EHR technology will need to include to support
1150 these health care providers, and the third creates the
1151 processes for EHR technology to be tested and certified, thus
1152 providing confidence and assurance to eligible health care
1153 providers that certify the EHR technology they adopt will
1154 perform as expected.

1155 On July 13th, with the issuance of the Medicare and
1156 Medicaid EHR incentive programs' final rule and the initial
1157 set of standards, implementation specifications and
1158 certification criteria final rule, a 17-month effort was
1159 capped to publish the three rulemakings necessary to
1160 implement meaningful use, stage 1. These rules cumulatively
1161 reflect over 2,000 public comments from stakeholders across
1162 the health care system and illuminate the initial pathway to
1163 achieving an integrated and electronically connected health
1164 care system. Our health information technology policy
1165 committee and health information technology standards
1166 committee played vital roles in advising me and the Secretary
1167 on these rules and many other matters.

1168 With the adoption of these three rules, attention now
1169 turns to their implementation. The ONC, the Office of the
1170 National Coordinator, is now ramping up the development of
1171 other processes that will need to be in place to enhance

1172 interoperability. Many of these processes will be components
1173 of a comprehensive standards and interoperability framework
1174 developed by the Office of the National Coordinate to
1175 expedite standards harmonization as well as their adoption
1176 and use.

1177 I am also pleased to report that in the approximately 4
1178 weeks since the temporary certification program rule was
1179 finalized, ONC has already distributed 32 applications to
1180 organizations seeking to become authorized testing and
1181 certification bodies to test and certify EHR technology. I
1182 am highly encouraged by the strong interest shown thus far
1183 and I am optimistic that multiple organizations will be
1184 granted ONC-authorized technology and certification body
1185 status and thus be authorized to test and certify complete
1186 electronic health records and EHR modules under the temporary
1187 certification program. Such a result should create a
1188 competitive market and would provide EHR technology
1189 developers with multiple options and could lower the costs to
1190 EHR technology developers that are associated with testing
1191 and certification.

1192 ONC has engaged in a number of cross-cutting activities
1193 related to administering the provisions of the HITECH Act.
1194 The major program investment established to date with the \$2
1195 billion appropriated to ONC under ARRA include the Health

1196 Technology Extension program, the State Health Information
1197 Exchange Cooperative Agreement program, the Beacon Community
1198 Cooperative Agreement program, the Health IT Workforce
1199 program, and the Strategic Health IT Advanced Research
1200 Projects program.

1201 The Health Information Technology Extension program
1202 includes the establishment of a national health IT research
1203 center and a nationwide network of regional extension
1204 centers. Regional extension centers will be dedicated to
1205 ensuring that providers have all the necessary resources to
1206 meet the challenges ahead to adopting and becoming meaningful
1207 users of certified electronic health record technology. They
1208 will place a special emphasis on providing technical
1209 assistance to clinicians furnishing primary care services
1210 from individual and small group practices.

1211 The State Health Information Exchange Cooperative
1212 Agreement program has the overall aim to advance appropriate,
1213 secure and sustainable health information exchange within and
1214 across States and other jurisdictions. Over \$500 million has
1215 been obligated to 56 States, eligible territories and
1216 qualified State-designated entities to support health care
1217 providers, demonstrate the meaningful use of certified
1218 electronic health record technology and to leverage the
1219 additional efficiencies and quality improvements gained from

1220 health information exchange.

1221 The Beacon Community Cooperative Agreement program
1222 provides certain communities with funding to build and
1223 strengthen their health IT infrastructure and health
1224 information exchange capabilities. These communities will
1225 demonstrate the vision of a future where hospitals,
1226 clinicians and patients are meaningful users of health
1227 information technology and together the community achieves
1228 measurable improvements in health care quality, safety,
1229 efficiency and population health.

1230 The HITECH Act provides for an unprecedented level of
1231 funding to improve the quality and efficiency of health care
1232 through HIT and its historic investment will undoubtedly help
1233 transition our current antiquated paper-dominated health care
1234 system into a high-performing 21st century health care
1235 system.

1236 It is my privilege to testify before you today and I
1237 look forward to continuing to work together in answering any
1238 questions you might have.

1239 [The prepared statement of Dr. Blumenthal follows:]

1240 ***** INSERT 1 *****

|
1241 Mrs. {Capps.} Thank you very much, Dr. Blumenthal.

1242 Now Mr. Trenkle for your testimony.

|
1243 ^STATEMENT OF ANTHONY TRENKLE

1244 } Mr. {Trenkle.} Thank you, Chairwoman. Chairwoman
1245 Capps, Ranking Member Shimkus and other members of the
1246 subcommittee, thank you for the invitation to discuss the CMS
1247 incentive program for electronic health records, which is
1248 part of the American Recovery and Reinvestment Act of 2009.
1249 Certified EHR technology use in a meaningful way is one piece
1250 of a broader health information technology infrastructure
1251 needed to reform our Nation's health care system and improve
1252 the quality and safety of care for both Medicare and Medicaid
1253 beneficiaries.

1254 On January 13, 2010, we published a proposed regulation
1255 that defined meaningful use and described the eligibility and
1256 payment methodologies for the EHR incentive programs. This
1257 NPRM was developed through close cooperation between CMS and
1258 the Office of National Coordinator and also allowed for
1259 extensive stakeholder input and recommendations from several
1260 federal advisory committees, in particular the HIT policy
1261 committee. The NPRM laid out three stages of meaningful use
1262 with stage 1 covering the first 2 years of the program. We
1263 received more than 2,000 comments on the proposed rule from
1264 interested stakeholders including health care providers,

1265 associations and patients. Most of the commenters felt that
1266 the proposed set of objectives was too difficult for stage 1
1267 and asked for some flexibility in meeting them. The agency
1268 carefully reviewed and considered all submitted comments and
1269 took them into account in making policy decisions for the
1270 final rule. Our goal was to be as inclusive and flexible as
1271 possible within the bounds of the statute. We continued to
1272 work closely with ONC and received additional recommendations
1273 from the HIT policy committee. It is important that this
1274 program provides payment incentives for both Medicaid and
1275 Medicare. The programs have different statutory requirements
1276 but we tried to harmonize the meaningful-use requirements as
1277 closely as possible for stage 1. Both the CMS rule and the
1278 ONC certification standard rule, which sets out the
1279 functionality requirements for EHR, were displayed the
1280 Federal Register on July 13, 2010, and will be published in
1281 the Federal Register tomorrow, July 28, 2010.

1282 I will now discuss some of the key areas of the final
1283 rule. Eligible professionals, the major change in that was
1284 to expand the definition of ``eligibility'' to hospital-based
1285 physicians who work primarily in outpatient departments.
1286 This is made possible by a change to the original statutory
1287 language made in the Continuing Education Extension Act of
1288 2010. Most Medicare Advantage-affiliated eligible

1289 professionals will also qualify for this incentive if they
1290 are able to show meaningful use, and on the Medicaid side we
1291 provide additional flexibility for determining patient volume
1292 in order to qualify more EPs.

1293 Eligible hospitals--we have received, as was noted by a
1294 number of the committee members, much comment and request
1295 that CMS recognize each campus of a multi-campus hospital for
1296 the incentive payments. We understand that this issue of
1297 importance to Members of Congress, the hospitals and the
1298 public. However, from the agency's perspective, we believe
1299 it is important to treat hospitals consistently, and the
1300 decision to deviate from longstanding policy in this
1301 particular instance without clear statutory direction to do
1302 so would have made CMS vulnerable to legal challenges
1303 asserting our policies are being implemented in an arbitrary
1304 manner. We intend to remain consistent with other payment
1305 policies and make incentive payments based upon how hospitals
1306 have organized themselves under provider numbers. There is a
1307 more detailed discussion of this issue in my written
1308 testimony and I am happy to respond to questions on this. We
1309 will continue to work with all interested stakeholders in
1310 future rulemaking related to the implementation.

1311 The other major hospital issue was with the Medicaid
1312 program, and in response to public comments on the proposed

1313 rule, we added critical-access hospitals to the definition of
1314 a Medicaid acute hospital in order to allow CAHs to qualify
1315 for both programs. The major changes we made in the rule
1316 were with the meaningful-use definitions. As we mentioned in
1317 the NPRM, we received a number of comments that asked for
1318 more flexibility, and we decided to make some changes based
1319 on these comments that I will address in the next few
1320 moments.

1321 Some of the major changes were modifying the all-or-
1322 nothing approach to objectives that must be met for
1323 meaningful use and reducing this requirement to a required
1324 set or a core and a menu set or optional set. Eligible
1325 hospitals and professionals have the flexibility to defer up
1326 to five of the menu set objectives. Where appropriate
1327 thresholds to meet meaningful-use requirements were reduced
1328 in the final rule in response to comments. We also removed
1329 the administrative transaction requirements in the final rule
1330 in response to comments these transactions are often done
1331 through practice management software as opposed to EHRs. We
1332 also modified the States' ability to impose more-robust
1333 requirements that would have made it more difficult for
1334 Medicaid providers to achieve elevated targets. We believe
1335 it is important for States to have some flexibility so we
1336 preserved the flexibility. However, in response to the

1337 concerns raised, it was limited to four public health
1338 measures. We also added additional objectives for patient-
1339 specific education resources and advanced directives for
1340 hospitals were added in response to numerous requests in the
1341 comments and the HIT policy committee recommendations.

1342 It is important to note that Medicaid providers are not
1343 required to meet meaningful-use criteria in their first
1344 participating year. Instead, they may qualify for an
1345 incentive payment if they adopt, implement or upgrade
1346 certified EHR technology. In subsequent years, Medicaid
1347 providers must demonstrate meaningful use in order to receive
1348 the EHR incentive payments. The meaningful-use definition
1349 described for Medicare will also be the minimum requirement
1350 for the Medicaid EHR incentive program. Unlike the Medicare
1351 program, however, there are no Medicaid penalties for EPs and
1352 hospitals that will unable to demonstrate meaningful use.

1353 Finally, I want to mention that Congress recognized the
1354 critical importance of reporting quality measures through
1355 EHRs in the HITECH legislation. We support this requirement
1356 but recognize that the infrastructure to support the
1357 reporting of quality measures through EHRs is not yet
1358 available. In response to comments, CMS limited CQMs to only
1359 those which have electronic specifications. Eligible
1360 providers will now be required to report on three core

1361 measures from a set of 41 measures. Hospitals will be
1362 required to report on 15 measures as applicable to their
1363 population.

1364 In conclusion, the CMS and ONC final rules lay the
1365 groundwork for establishing a robust national health care
1366 infrastructure that supports the adoption of EHR technology
1367 that can help providers practice safer, more effective
1368 medicine. CMS understands the scope of these programs is
1369 vast and the doctors and facilities across the country have
1370 varying awareness of EHRs and of the program. We are working
1371 closely with ONC to conduct wide-scale outreach to educate
1372 those eligible for the program as well as working with the
1373 States and provider stakeholders. We look forward to working
1374 with Congress and our many stakeholder partners as we
1375 implement this rule and future rules and advance the use of
1376 HIT in our health care system.

1377 Thank you very much for allowing me to testify.

1378 [The prepared statement of Mr. Trenkle follows:]

1379 ***** INSERT 2 *****

|
1380 Mrs. {Capps.} Thank you, Mr. Trenkle. And the
1381 statements of both of our witnesses in the first panel will
1382 be made a part of the hearing record. Each witness may also
1383 submit additional pertinent statements in writing and at the
1384 discretion of committee be included in the record, and now I
1385 recognize myself for 5 minutes of questioning.

1386 My first question is for you, Dr. Blumenthal. Dr.
1387 Blumenthal, I believe that health information technology will
1388 benefit all of us but it can also be particularly important
1389 in improving the health of individuals with complicated
1390 comorbidities such as people with severe mental illness. I
1391 am aware that mental health providers are not authorized to
1392 participate in Medicaid and Medicare reimbursement under the
1393 HITECH Act. Because of that omission, I am a cosponsor of a
1394 bill I want to acknowledge by our colleague here, Mr. Murphy,
1395 and our colleague in Congress, Mr. Kennedy, H.R. 5040, to
1396 correct that situation. I do worry that without health
1397 information technology it will becoming increasingly
1398 difficult for behavioral health providers to provide the
1399 necessary coordinated care for people with serious mental
1400 disorders. They cannot receive reimbursement for adopting
1401 HIT. Can behavioral health providers participate in any part
1402 of the HITECH Act technical assistance regional extension

1403 center program and will you describe that for us?

1404 Dr. {Blumenthal.} Sure. Thank you, Madam Chair. Well,
1405 as a long-term primary-care physician, I well understand the
1406 value of behavioral health information. I treated many
1407 patients with dual diagnoses, that is behavioral health and
1408 problems or substance-abuse problems as well as so-called
1409 physical problems. So it is absolutely vital that that
1410 information be available for accurate and careful management
1411 of patients. There is no question that the regional
1412 extension centers can serve any physician who is using
1413 electronic health record and intends to become a meaningful
1414 user of that electronic health record. There are certain
1415 priority providers that we have outlined in order to achieve
1416 the intent of the law and we have focused on primary-care
1417 physicians, critical-access hospitals, physicians in small
1418 groups and in underserved areas but there is no restriction
1419 that prevents a regional extension center in addition from
1420 serving mental health providers.

1421 Mrs. {Capps.} And you are reaching out to these
1422 communities?

1423 Dr. {Blumenthal.} Yes, we are.

1424 Mrs. {Capps.} Okay. So that they know about what
1425 services they can be eligible for?

1426 Dr. {Blumenthal.} We certainly are making every effort

1427 to make those services known.

1428 Mrs. {Capps.} May I also mention another topic? The
1429 HITECH Act provided \$2 billion to the Office of the National
1430 Coordinator for Health Information Technology, partly to
1431 build an infrastructure that promote the electronic exchange
1432 and use of health information. Can you describe how the
1433 health information network and the health information
1434 exchanges are critical to this effort?

1435 Dr. {Blumenthal.} Well, exchange is absolutely
1436 essential to good health-care management. Knowing what your
1437 patients' experiences have been in other locations is a great
1438 benefit, potential benefit of health information technology.
1439 At the same time, we need to make it possible for exchange to
1440 occur. It is not something that is under the control of
1441 individual providers. Exchange is in many ways a team sport.
1442 You need to have someone out there to get your pass when you
1443 throw the pass and you need to be able to take the pass when
1444 it comes back to you. So the health information exchange
1445 cooperative agreement programs that provide funds to the
1446 States are meant to empower the States and encourage the
1447 States to lead in the development of health information
1448 exchange capabilities within state jurisdictions and across
1449 state jurisdictions. Similarly, the Office of the National
1450 Coordinator has undertaken an aggressive program for the

1451 development of new standards and technologies that can
1452 provide a tool kit for exchange that the States can use and
1453 that local service providers can use.

1454 Mrs. {Capps.} One final question to you. Your office,
1455 I know, has been in touch with the providers that are
1456 required to start exchanging health information
1457 electronically but once they have begun that, is there the
1458 national infrastructure to allow it to continue to work
1459 forward? In other words, are you building a network? I have
1460 just a half a minute left for you to respond.

1461 Dr. {Blumenthal.} We want very much for this to be an
1462 ongoing feature of the health-care system and of health
1463 information technology so we are working hard with our health
1464 information exchange groups at the State level to make them
1465 sustainable over time.

1466 Mrs. {Capps.} So there is a network that is building
1467 within the State and then will that filter--

1468 Dr. {Blumenthal.} Absolutely. That network has to be
1469 created or else exchange will not continue.

1470 Mrs. {Capps.} Thank you very much.

1471 Mr. Shimkus.

1472 Mr. {Shimkus.} Thank you, Madam Chair.

1473 First, I want to segue into and follow on the line of
1474 questioning that Mrs. Capps talked about. Also, there is a

1475 provision on the absence of physical therapy as part of being
1476 not eligible to receive and I just want to throw that out
1477 there. I think your answer would be very similar in the
1478 response. But I think it is worth noting that there are some
1479 gaps there and there will be a debate on who is eligible and
1480 who is not eligible.

1481 Dr. Blumenthal, what happens to eligible professionals
1482 and hospitals that fail to meet the meaningful-use
1483 requirements? Are they penalized? Will they be penalized?

1484 Dr. {Blumenthal.} Well, Congressman, the law specifies
1485 what will happen for failure to meet meaningful use.

1486 Mr. {Shimkus.} And since you are implementing that law,
1487 what would that be?

1488 Dr. {Blumenthal.} Well, as of 2015, eligible providers
1489 that have not implemented, not become meaningful users would
1490 be potentially penalized in their Medicare and Medicaid--

1491 Mr. {Shimkus.} When? When will that start? When will
1492 the penalties start?

1493 Dr. {Blumenthal.} Twenty fifteen.

1494 Mr. {Trenkle.} Yes, 2015 is specified in the
1495 legislation.

1496 Mr. {Shimkus.} We don't have any idea based upon where
1497 people are in a survey of projection of how many providers
1498 may be penalized?

1499 Dr. {Blumenthal.} I think it would be premature to
1500 speculate about that.

1501 Mr. {Trenkle.} We put some estimates in the impact
1502 analysis as part of the regulation, but--

1503 Mr. {Shimkus.} And what would those analyses show?

1504 Mr. {Trenkle.} We had both a high- and a low-end
1505 projection for that.

1506 Mr. {Shimkus.} I will give you a chance to look for
1507 that.

1508 Mr. {Trenkle.} No, I have got them right here,
1509 actually. The projection we had on the low end was by 2015,
1510 21 percent of EPs would be meaningful users, and on the high
1511 end, 53 percent would be meaningful users, but keep in mind
1512 that that represents numbers based on previous studies that
1513 our actuaries used to come up with these numbers. They don't
1514 take into account what the effects of outreach and other
1515 activities that will be done under this Act will do.

1516 Mr. {Shimkus.} You know, and I think from colleagues on
1517 both sides of the aisle, especially those of us who represent
1518 rural communities, I think, you know, our one of many
1519 concerns would be major institutions have the capital or the
1520 foundations to move in the aggressively upfront cost. Poor,
1521 rural hospitals do not, and our concern is the timeline and
1522 our concern would be then when they are servicing in poor

1523 areas that they will then have a penalty when they are still
1524 trying to comply. So that is part of the question.

1525 Mr. {Trenkle.} Excuse me just a second, but the numbers
1526 I gave you were for the professionals, not for the hospitals.

1527 Mr. {Shimkus.} Well, it is true for them too.

1528 Mr. {Trenkle.} Right. I understand.

1529 Mr. {Shimkus.} What about the other issue that we have
1530 heard of is interoperability between the family practitioner
1531 and maybe the hospital, and the question would be, and it
1532 deals with the incentive payment issues. Who would pay if
1533 you have two systems that are not compatible and then you
1534 have to develop a compatibility software system? The family
1535 practitioner may balk and say well, that is our deal. The
1536 hospital may say well, that is not our deal. How are you
1537 going to take into consideration those issues?

1538 Dr. {Blumenthal.} Well, one of the reasons why we put
1539 back to stage 2 some of the more complete exchange
1540 capabilities was to give the local providers a chance to work
1541 those things out, come to agreements locally on who is going
1542 to do what to create exchange. I think the two key factors
1543 at work here are the incentives which will be available if
1544 exchange occurs, and perhaps for some the avoidance of
1545 penalties. And the second, the availability of good tools
1546 for exchange including open source free software, which we

1547 are developing.

1548 Mr. {Shimkus.} And my time is real short, but I want to
1549 just ask, in your testimony, Mr. Trenkle, you have a range of
1550 estimates between \$9.7 billion and \$27.4 billion over the
1551 next 10 years, and that is a pretty large range. Can you
1552 explain why that is the case and that can't be narrowed down
1553 a little bit more?

1554 Mr. {Trenkle.} For the purpose of the impact analysis,
1555 we did both a high- and a low-end scenario. As I mentioned a
1556 few moments ago, those are based on studies and actuarial
1557 projections. We also changed some of the numbers based on
1558 input we received from a number of organizations including
1559 the American Hospital Association, which allowed us to
1560 actually we had to lower the lower end because some of the
1561 cost projections and projections of getting up to speed had
1562 to be lowered because of the longer implementation lead time
1563 they projected.

1564 Mr. {Shimkus.} Thank you, Madam Chair.

1565 Mrs. {Capps.} Mr. Waxman, the chairman of the full
1566 committee, is recognized for his questions.

1567 The {Chairman.} Thank you, Madam Chair.

1568 The gathering of health IT should not be a goal in
1569 itself. It a worthy goal, but that is not the only reason we
1570 want it. The lack of timely clinical information is a

1571 contributor to our Nation's well-documented problems with
1572 uncoordinated care. Health IT is a tool that can help deal
1573 with that problem right at the time of the patient's visit.
1574 The health reform legislation contains numerous policies to
1575 improve the delivery system such as establishing accountable
1576 care organizations, reducing hospital readmissions and moving
1577 towards greater bundling of services.

1578 Dr. Blumenthal and Mr. Trenkle, what role with health IT
1579 play in making sure these kinds of delivery system reforms
1580 are successful?

1581 Dr. {Blumenthal.} Well, Mr. Chairman, you can't have
1582 accountable care organizations without knowing how to make
1583 them accountable, and to be accountable you need to know what
1584 you are doing, and health IT is the best possible source of
1585 good information about performance in real time quickly.
1586 Once you have a system up and going, the system should
1587 generate information about quality and efficiency and cost in
1588 real time as a product of the work, not post-retrospectively
1589 through chart review, which is costly, lengthy, and by the
1590 time it is available often no longer relevant to the
1591 performance of the organization. So it is really I think
1592 enormously empowering for enabling providers to take
1593 responsibility for their performance.

1594 Mr. {Trenkle.} I would follow up on what Dr. Blumenthal

1595 with the fact that we are actually building infrastructure
1596 over the next several years that will support much of the
1597 health reform from the electronic specifications for the
1598 quality measures to the health information exchanges and the
1599 other work we are doing will allow us to have the
1600 infrastructure, that will allow the flow of data and support
1601 many of the objectives of health reform, so we feel this is a
1602 critical first step in moving towards some of the goals set
1603 out in the legislation.

1604 The {Chairman.} Is it fair to say that without health
1605 IT we wouldn't be able to have the reforms be as successful
1606 as we hope them to be?

1607 Dr. {Blumenthal.} Well, I would certainly agree with
1608 that, Mr. Chair.

1609 The {Chairman.} Now, there is another value in
1610 electronic health records. The availability of information
1611 in these records has the potential to support population
1612 research to better understand disease and treatment patterns.
1613 What plans are underway with other agencies to make use of
1614 the information for public health planning and what role do
1615 you think this can play in improving the quality and
1616 efficiency of health care delivery?

1617 Dr. {Blumenthal.} That is an excellent question. We
1618 are working with our sister agencies to try to define how

1619 records can privately and securely capture and make available
1620 information that is relevant to the missions of other
1621 agencies like the Food and Drug Administration or the
1622 National Institutes of Health or the Agency for Health
1623 Research and Quality or the Centers for Disease Control and
1624 Prevention, how we can, for example, in real time learn about
1625 the occurrence of influenza-like illness so that we can keep
1626 track of influenza epidemics and know where vaccine needs to
1627 be administered or keep track of foodborne illness outbreaks
1628 though real-time availability of information on related types
1629 of illness. So there is an enormous public health benefit
1630 and there is enormous value with patient consent and
1631 agreement recruiting patients into clinical trials for
1632 relevant new experiments whether it is in cancer or heart
1633 disease or diabetes, patients who want to be part of these
1634 experiments but who might otherwise be located without the
1635 benefit of the information that is available in electronic
1636 form.

1637 Mr. {Trenkle.} Let me also mention that under the
1638 meaningful-use objectives, one of the major goal areas was to
1639 improve population in public health and we included a number
1640 of objectives that provide for the capability to exchange
1641 public health data, and as I mentioned in my testimony
1642 earlier, we are also allowing States to have the flexibility

1643 to make some of these objectives core measures and core
1644 objectives for the purposes of meeting the meaningful-use
1645 criteria for the incentive program.

1646 The {Chairman.} Thank you. I yield back my time.

1647 Mrs. {Capps.} Thank you, Mr. Chairman.

1648 The Chair recognizes Mr. Gingrey for 5 minutes of
1649 questioning.

1650 Dr. {Gingrey.} Madam Chair, thank you very much.

1651 I don't know who to ask this so I will ask both of you.
1652 The HIT policy committee adoption certification work group
1653 recently recommended that ONC work with the FDA and
1654 representatives of patient clinician vendor and health care
1655 organizations to determine the role that the FDA would play
1656 to improve the safe use of certified electronic health record
1657 technology. Recently the FDA has suggested that direct-to-
1658 consumer genetic tests--we had a hearing on that just last
1659 week--that those should be classified as medical devices for
1660 the purpose of oversight. Do either of you believe that the
1661 FDA should consider electronic medical records as medical
1662 devices for the purposes of regulating these records?

1663 Dr. {Blumenthal.} Congressman, our concern and the
1664 concern of the policy committee that you cited was to take
1665 maximum advantage of health information technology and
1666 electronic health records to improve the safety of concern,

1667 and what actually the committee focused on in addition to the
1668 FDA was other alternatives for collecting information about
1669 the implementation of electronic health records to make sure
1670 that those implementations are as safe as they could possibly
1671 be. So we also discussed using patient safety organizations
1672 and using our new certification to collect post-market, post
1673 surveillance, post-certification surveillance information.
1674 So I think that the mandate to us, the recommendation to us,
1675 not a mandate, was to develop and look at all the ways we
1676 could collect information to make sure that our work was
1677 doing everything it possibly could to enhance patient safety.

1678 Now, whether or not the Food and Drug Administration
1679 takes any action beyond what it already has I think is
1680 premature to speculate about. They have no plans right now
1681 that I am aware of to do anything further than what they have
1682 already done. So we are right now at the Department looking
1683 at these information collection opportunities that we already
1684 have and have created and not looking at anything else beyond
1685 that.

1686 Dr. {Gingrey.} Mr. Trenkle, do you have any further
1687 comments on that?

1688 Mr. {Trenkle.} No, I agree with what Dr. Blumenthal
1689 said.

1690 Dr. {Gingrey.} I thank you. I hope that I understood

1691 correctly your response, Dr. Blumenthal, that you really
1692 don't think that the FDA should treat electronic medical
1693 records as a medical device.

1694 Dr. {Blumenthal.} Well, there are issues, there are
1695 legal issues which I am not qualified to speculate about as
1696 to what a device is or isn't. From the standpoint of policy,
1697 I would say there is no plan right now for the FDA to do
1698 anything of that sort.

1699 Dr. {Gingrey.} Thanks. I have got about 2 minutes
1700 left.

1701 Technology companies have told me, and we have a very
1702 good one in my district, the 11th of Georgia, in Carrollton,
1703 Georgia, I won't mention the name of the company but they are
1704 very good and they have been out there doing this for a
1705 while, that is, providing electronic medical record hardware
1706 and software to specialty-specific groups, general surgery,
1707 OB/GYN, et cetera, and they have told me how critically
1708 important it will be to have 12 to 18 months of lead time in
1709 order to align their products with the stage 2 criteria.
1710 Understanding how critically important quality products are
1711 to the viability of our future nationwide network, can you
1712 give these companies like the one in my district some public
1713 reassurance today that the development of stage 2 criteria
1714 will allow these companies a 12- to 18-month window in order

1715 to bring their products into compliance?

1716 Dr. {Blumenthal.} We are going to do everything we can
1717 to give companies as much warning as we can about what the
1718 criteria will be, and we want to have time to learn from
1719 stage 1 about what the experience has been of providers and
1720 vendors and others, patients, with the new rules and
1721 implementation efforts. So we want to wait a while before we
1722 get that experience. Then we also want to get the rules done
1723 as early as possible.

1724 Dr. {Gingrey.} Well, I don't want to interrupt you, but
1725 I definitely want to ask Mr. Trenkle a question before my
1726 time runs out. I have 10 seconds.

1727 You said to one of my colleagues that the issue of the
1728 final rule on the hospitals that have multiple campuses, that
1729 they would just be eligible for one meaningful-user incentive
1730 payment for Medicare and Medicaid. How about physician
1731 groups, let us say a family practice group of five individual
1732 physicians, they are affiliated in some way, how would you
1733 deal with them? Would that group only be eligible for one
1734 payment, \$44,000 or \$77,000, whatever it is, or multiple
1735 payments for each individual doctor?

1736 Mr. {Trenkle.} I just want to add one thing to the
1737 previous question on the meaningful use stage 2. We have, in
1738 addition to what David mentioned, we have also signaled in

1739 the preamble for this particular rule that we were going to
1740 move the menu items to the core objectives for stage 2 and
1741 also signaled our intent to add administrative transactions
1742 in stage 2 as well as increasing the percentage measurement
1743 for computerized physician order entries. So we have given
1744 some signals.

1745 But to answer your second question, we have--for this
1746 particular rule, we have payments are made to individual
1747 eligible professionals so they are not made by group, they
1748 are made by professionals, and we made that decision very
1749 much after listening to some of the comments, reading some of
1750 the comments that came in and listening to some of the
1751 concerns that people had on both sides where they felt the
1752 way the legislation was written and the ability to track the
1753 dollars spent in the performance to meet the criteria, we
1754 have determined that we would go with the individual eligible
1755 professionals. So if there is five members of a group
1756 practice, each one of them would have to show meaningful use
1757 to meet the requirements to get an incentive.

1758 Dr. {Gingrey.} But they would each be eligible if they
1759 did for the bonus payment?

1760 Mr. {Trenkle.} That's correct.

1761 Dr. {Gingrey.} Mr. Chairman, thank you. I thought that
1762 was very important. I am glad you let him answer.

1763 Mr. {Pallone.} Thank you.

1764 Our chairman emeritus, Mr. Dingell, is recognized.

1765 Mr. {Dingell.} Thank you, Mr. Chairman.

1766 Dr. Blumenthal, would you agree that lack of certified
1767 EHR technology has the potential to hinder our progress and
1768 discourage physicians from participating in the EHR
1769 incentive, yes or no?

1770 Dr. {Blumenthal.} I don't think that is going to be a
1771 problem, Mr. Dingell.

1772 Mr. {Dingell.} It does have the potential, though, does
1773 it not?

1774 Dr. {Blumenthal.} If certified technology were not
1775 available, yes, it would have that.

1776 Mr. {Dingell.} Now, if eligible providers don't know
1777 which technology will eventually pass the test, they will be
1778 slow to go out and buy it. Isn't that correct?

1779 Dr. {Blumenthal.} I don't think that is going to
1780 happen, but yes, that is correct.

1781 Mr. {Dingell.} It is a possibility. So it is critical
1782 that we have a strong certification program in place as soon
1783 as possible to provide some level of certainty for providers.
1784 Do you agree with that?

1785 Dr. {Blumenthal.} I agree with that.

1786 Mr. {Dingell.} And I don't want you to be defensive

1787 about this. I just want you to understand, I have the
1788 apprehension if we don't make these things flow, there is
1789 going to be trouble.

1790 Now, while the Medicare/Medicaid incentive programs
1791 begins next year, the permanent certification program is not
1792 expected to be fully operational until early 2012. Is that
1793 correct?

1794 Dr. {Blumenthal.} That is correct.

1795 Mr. {Dingell.} Now, what has the Administration done to
1796 remove the potential uncertainty surrounding certification to
1797 ensure that we have as much as early participation for
1798 providers as possible?

1799 Dr. {Blumenthal.} Well, we have already published in
1800 mid-June a final rule creating a temporary certification
1801 process which will be in existence until the final permanent
1802 process is available. That process can certify records, will
1803 certify records, will certify them by the fall, so that we
1804 believe there will be ample time for eligible providers to
1805 have not only installed a record but have some time to look
1806 them over, think about what they want to install, and then
1807 some time to install them, and still qualify for the full
1808 payments available under the incentive plan.

1809 Mr. {Trenkle.} Congressman Dingell, can I make a
1810 comment also? One of the things we took into account when

1811 establishing the criteria for meaningful use is to have a 90-
1812 day reporting period in year one in recognition of the fact
1813 it will some time to set up the certification program and
1814 also to allow the providers and hospitals additional time to
1815 sign up for the program and demonstrate meaningful use.

1816 Mr. {Dingell.} Thank you. I think you are both telling
1817 me then that the temporary program is necessary but that it
1818 is not going to be sufficient over the long haul. Is that
1819 correct?

1820 Dr. {Blumenthal.} The temporary program will be, we
1821 hope, a high-quality program but it won't meet all the
1822 criteria that certification bodies should meet in order to
1823 meet international standards.

1824 Mr. {Dingell.} Now, will the technology certified
1825 through the temporary program be subjected to additional
1826 certification under the permanent program?

1827 Dr. {Blumenthal.} It will continue to be certified for
1828 stage 1 until additional criteria come into play.

1829 Mr. {Dingell.} Now, Dr. Blumenthal, I note that HITECH
1830 has made substantial program investments including funding
1831 for support of the Beacon Community Cooperative Agreement
1832 program. The first round of awards were announced, and I
1833 understand that there were strong applications from Michigan,
1834 but I also understand that none of the Michigan applications

1835 were selected. Am I correct that you plan to announce two
1836 additional awards?

1837 Dr. {Blumenthal.} You are correct, sir.

1838 Mr. {Dingell.} And am I to assume that Michigan will be
1839 most sympathetically considered?

1840 Dr. {Blumenthal.} We will give it every sympathetic
1841 consideration, sir.

1842 Mr. {Dingell.} I will be looking forward to that. What
1843 will be the timeline for this announcement?

1844 Dr. {Blumenthal.} Middle of August, I believe.

1845 Mr. {Dingell.} Beg your pardon?

1846 Dr. {Blumenthal.} Mid-August, I believe.

1847 Mr. {Dingell.} Now, I would like to get your assessment
1848 of the current EHR marketplace. HITECH included a provision
1849 that would require your office to make certified EHR
1850 technology available if the marketplace fails to do so. Is
1851 that correct?

1852 Dr. {Blumenthal.} That is correct.

1853 Mr. {Dingell.} Now, what is your current assessment of
1854 the marketplace? Do you feel that there is adequate
1855 innovation currently going on so that I don't need to be
1856 apprehensive about the prior point?

1857 Dr. {Blumenthal.} I do believe so.

1858 Mr. {Dingell.} Mr. Chairman, I note my time has expired

1859 and I thank you for your courtesy.

1860 Mr. {Pallone.} The gentleman from Texas, Mr. Burgess.

1861 Dr. {Burgess.} I thank the chairman.

1862 Dr. Blumenthal, the American Medical Association in the
1863 brief that was submitted by Dr. Gingrey for the record makes
1864 note about the need for small physician practice
1865 representation on your policy committee. How are you
1866 addressing that?

1867 Dr. {Blumenthal.} I think that is a fair point. We
1868 certainly want to make sure that we have heard from the full
1869 spectrum of physician practices and perspectives so we would
1870 be, I think, open to that suggestion.

1871 Dr. {Burgess.} Another thing that I have encountered, I
1872 don't know if it has come up--

1873 Dr. {Blumenthal.} Congressman, if I could just make one
1874 amendment to that?

1875 Dr. {Burgess.} Yes.

1876 Dr. {Blumenthal.} The membership of that committee is
1877 actually determined by the GAO and the Congress and then
1878 specified by law as to who else the Secretary can appoint.
1879 The only way we could appoint small physician practice
1880 representatives would be as a member of a working group, not
1881 as a member of the policy committee per se. That is just a
1882 matter of the way the law is written.

1883 Dr. {Burgess.} How many of those working groups do you
1884 have?

1885 Dr. {Blumenthal.} We have several, so it would be quite
1886 possible to include them.

1887 Dr. {Burgess.} I would also then ask you to consider, I
1888 know I have heard from a number of physicians who practice
1889 orthopedics that they face a particular challenge in
1890 instituting this technology from their offices and that the
1891 packages that are available to them, the products that are
1892 available to them that also include digital imaging, the
1893 broadband requirements are so high, the storage requirements
1894 so high that they are sometimes looking at systems that cost
1895 in excess of several hundreds of thousands of dollars which
1896 obviously is a barrier to entry. So I would encourage you to
1897 hear voices from across the spectrum of the real world in
1898 practice because ultimately these are the individuals you are
1899 going to count on to make this work, and if it is not
1900 workable for them, clearly we will have a problem.

1901 What happens to professionals who fail to meet the
1902 meaningful-use requirements?

1903 Dr. {Blumenthal.} Well, in the period between 2011 and
1904 2015, they fail to accumulate the incentive payments that are
1905 available. In 2015 and beyond, they are subject to the
1906 penalties that were placed in the law with respect to

1907 Medicare reimbursement.

1908 Dr. {Burgess.} So if a practice elects to do nothing,
1909 it is not that they will just ultimately be left alone, they
1910 ultimately would be penalized by the provisions of HITECH and
1911 ARRA?

1912 Mr. {Trenkle.} Yes, if they are under the Medicare
1913 program if they quality.

1914 Dr. {Burgess.} And what--

1915 Mr. {Trenkle.} And that was legislatively mandated.
1916 That was part of--

1917 Dr. {Burgess.} But what are the penalties that they are
1918 looking at?

1919 Dr. {Blumenthal.} I will let Mr. Trenkle answer that.

1920 Mr. {Trenkle.} The penalties are as they were put into
1921 the legislation. It is 1 percent in 2015 and then it goes
1922 upward beyond that, but we implement them as they were put
1923 into the legislation.

1924 Dr. {Burgess.} And just for the record, I argued
1925 strenuously against that type of punitive approach to this
1926 because I don't know if we have allowed ourselves enough time
1927 to ramp this up. Dr. Blumenthal, you have worked a Herculean
1928 effort this past year to get where you are right now.

1929 Imagine putting that effort on top of a small physician
1930 practice working 16 hours a day just to take care of their

1931 patients and pay their bills and keep their doors open with
1932 all of the other stipulations we have put up them. This one
1933 does seem onerous. For either of you, how many providers are
1934 going to be penalized? Do you have some notion as to how
1935 extensive this is going to be?

1936 Dr. {Blumenthal.} There are estimates that were made by
1937 the Office of the Actuary which I will let Mr. Trenkle
1938 summarize, but I will add a prior comment to say that all
1939 those estimates were based on experience prior to the
1940 availability of incentives and prior to the availability of
1941 the regional extension center program, the Beacon community
1942 program, our workforce training program and all the other
1943 efforts we are making to assist providers in becoming
1944 meaningful users.

1945 Mr. {Trenkle.} As I had mentioned earlier in a similar
1946 question, we had scenarios both high and low in the impact
1947 analysis that were compiled by our actuaries using data from
1948 studies and other information that they had.

1949 Dr. {Burgess.} Maybe you could get back to me with that
1950 in writing because I am going to run out of time and I would
1951 be interested in your response to that.

1952 Mr. {Trenkle.} Okay.

1953 Dr. {Burgess.} But I guess one of the other follow-up
1954 questions I have is, obviously there are going to be people

1955 who have these systems for sale. Now, the people who have
1956 the systems for sale, the vendors, are they under any sort of
1957 punitive aspects under this law or do they just simply
1958 present their wares for sale and that is that?

1959 Mr. {Trenkle.} No, they are not under any penalties.
1960 The only issue with the payment adjustments was what was in
1961 the legislation.

1962 Dr. {Burgess.} Let me just see if I have this right.
1963 The doctors are under penalty, under threat of penalty if
1964 their practices are not compliant, but the doctors
1965 technically don't really make any money off of having an
1966 electronic medical records system. It may be good practice
1967 and it may be important for patient safety but they don't
1968 actually benefit on the bottom line from these systems and
1969 yet the vendors are going to significantly benefit from the
1970 forced sale to practices of these systems. Are you doing
1971 anything to mitigate that discrepancy?

1972 Dr. {Blumenthal.} Well, the provisions of the law are
1973 the provisions of the law, Mr. Congressman, as you well know,
1974 so we have limited--what we are doing is working very hard to
1975 make sure that every well-intended provider who wants to be a
1976 meaningful user has the opportunity to become a meaningful
1977 user and that--but they won't fail to through any lack of
1978 effort on our part. So that is I think our commitment at the

1979 Office of the National Coordinator and from the federal
1980 government.

1981 Dr. {Burgess.} But with all due respect--

1982 Mr. {Pallone.} The gentleman's time is a minute and a
1983 half over.

1984 Dr. {Burgess.} I will follow up with this in writing
1985 because this is an important point, and we have already seen
1986 how your rulemaking has progressed since the beginning of the
1987 year, and it is going to affect practices all over the
1988 country.

1989 Mr. {Pallone.} Thank you. Let me mention that you will
1990 get additional questions from us in writing, and any member
1991 is entitled to do that.

1992 The gentlewoman from the Virgin Islands, Ms.
1993 Christensen.

1994 Dr. {Christensen.} Thank you, Mr. Chairman, and thank
1995 you both, Dr. Blumenthal and Mr. Trenkle.

1996 My first question is to you, Mr. Trenkle. The
1997 territories are not included in the EHR program under
1998 Medicare and Medicaid. It is just the 50 States and the
1999 District of Columbia. Is the reason because we don't use a
2000 prospective payment program? I don't see why that should
2001 make a difference but you can explain if it does. And
2002 Medicaid is different in the territories, and while I don't

2003 agree with that either, Medicare is not. And in the
2004 territories, Medicaid can only be used in public hospitals
2005 and public clinics. So why are we excluded?

2006 Mr. {Trenkle.} In determining eligible professionals
2007 and hospitals, we followed what was in the statute.

2008 Dr. {Christensen.} Okay. So we did it?

2009 Mr. {Trenkle.} Right, so you did it.

2010 Dr. {Christensen.} We will try to see what we can do
2011 about that because it really shouldn't--in the territories,
2012 Medicare beneficiaries and Medicaid beneficiaries should
2013 benefit from the same benefits of HIT as everyone else.

2014 Don't you agree?

2015 Mr. {Trenkle.} Yes, I agree. As I said, we followed
2016 what was in the statute, so--

2017 Dr. {Christensen.} Thank you.

2018 Dr. Blumenthal, on the Beacon Community Cooperative
2019 Agreement program, and we heard that the first round has been
2020 awarded, certain communities are provided with funding to
2021 build and strengthen the HIT infrastructure and HIT
2022 capabilities. Could you describe briefly the criteria for
2023 other communities that are chosen? I am trying to get at--
2024 and if you know this, if you would help me to understand,
2025 what proportion of racial and ethnic minorities and low-
2026 income communities were served in the first round?

2027 Dr. {Blumenthal.} Well, I would like to get back to you
2028 with specific numbers. I can tell you that my memory is that
2029 the communities' populations are representative of the
2030 underserved populations in the country as a whole. The
2031 beacon community program was awarded, vendors were chosen
2032 through an objective review competitive process. As a matter
2033 of fact, it took place in the record-breaking snowstorm in
2034 February, and we funded those programs in the order in which
2035 they were picked by the external reviewers, just as an NIH
2036 grant would be awarded. The criteria took into account of
2037 course the quality of the application. It did take into
2038 account diversity. Seven of the 15 are rural communities.
2039 And it took into account the commitment of the communities,
2040 the quality of the health IT infrastructure, the governance
2041 arrangements and the believability, the credibility of their
2042 goals which were very precisely laid out in the applications.

2043 Dr. {Christensen.} Did you identify or have to respond
2044 to any unique challenges in the implementation process or
2045 through the comment process from poor, rural or communities
2046 of color?

2047 Dr. {Blumenthal.} We certainly tried to. There is a
2048 beacon community in the Mississippi delta. There is one in
2049 the Piedmont area of North Carolina. There is one in Tulsa,
2050 Oklahoma. So they really go from Hawaii to upper New York

2051 and I think are quite representative of the country as a
2052 whole.

2053 Dr. {Christensen.} And I guess to both of you, and you
2054 may have answered this already but I didn't see it in reading
2055 your testimony specifically. How have the providers been
2056 incorporated into the setting of the standards, not just in
2057 the comment period but as you were developing the standards?
2058 Were doctors, hospitals, other providers included?

2059 Dr. {Blumenthal.} We have two advisory committees that
2060 you all provided us under the statute, the policy committee
2061 and standards committee. They meet in public. Their work
2062 groups meet in public. We have had over 180 public meetings
2063 of those groups. We have had testimony from a wide range of
2064 advisors.

2065 Dr. {Christensen.} One other question. I am sorry. I
2066 am hearing your answer. But there is room, because many
2067 older doctors are used to dictating. Is there room in EHR
2068 for including the dictation transcription process in the
2069 implementation since that might provide an easier transition?
2070 I needed to get that question and I have to leave, so I am
2071 sorry for cutting you off but I hear where you were going
2072 with your answer.

2073 Dr. {Blumenthal.} Well, progress notes are not part of
2074 the requirement for meaningful use in stage 1, so yes, there

2075 would be an opportunity to dictate into the record in stage
2076 1.

2077 Dr. {Christensen.} Thank you, Mr. Chairman.

2078 Mr. {Pallone.} Thank you.

2079 Next is the gentleman from Ohio, Mr. Space.

2080 Mr. {Space.} Thank you, Mr. Chairman.

2081 Mr. Trenkle, like many of my colleagues, the hospitals,
2082 as I mentioned in my opening, in my Congressional district
2083 are going to be impacted, at least some of them, by your
2084 decision on multiple-campus hospitals, and in fact, Genesis,
2085 which is one of the largest hospitals in my district in
2086 Zanesville, Ohio, the largest city in my district, stands to
2087 lose about \$2 million in incentive payments based on your
2088 rule and, as you might understand, they are little frustrated
2089 by that rule. Won't decisions like this ultimately make it
2090 more difficult for hospitals like Genesis Hospital to adopt
2091 the very technology that this law is designed to promote?

2092 Mr. {Trenkle.} As I mentioned in my written and in my
2093 oral testimony that we base this on existing policy and the
2094 provider number is based on how the hospitals choose to
2095 organize themselves for payments under other Medicare
2096 programs, so what we did here without clear statute intent
2097 was to be consistent with the payment policies that we have
2098 adopted for other programs, many of which, as I said, were

2099 due to hospitals themselves wanting to be organized in this
2100 manner to be paid in a certain way.

2101 Mr. {Space.} So absent clear statutory intent, at this
2102 point you don't envision reconsideration of that rule?

2103 Mr. {Trenkle.} That is correct, although we are happy
2104 to be working with committee staff and others to look at
2105 potential ways to work with us. We recognize that there has
2106 been a lot of public comment as well as comment from
2107 yourself, your staff and other staffs here that express
2108 concerns about them. We have heard, of course, from many
2109 hospital groups as well.

2110 Mr. {Space.} I appreciate your working with us on it
2111 because it is a real problem for us and for our health care
2112 providers which already are at so many disadvantages, given
2113 the rural nature of our district, and the class of patients,
2114 the Medicare, Medicaid, self-pay percentages are so high. In
2115 fact, we have got one hospital now that is desperately
2116 attempting to avoid bankruptcy and if these hospitals can't
2117 survive, it will have a direct and profound impact on the
2118 folks that live in places like Ohio's 18th district, and
2119 broadband and health IT represents an opportunity to bridge
2120 many of the divides that exist between rural America and
2121 urban and suburban area. So I am grateful that you have
2122 expressed a willingness to work with us.

2123 Dr. Blumenthal, I understand last week you testified
2124 before Ways and Means and you mentioned that Secretary
2125 Sebelius had convened a working group on rural providers.
2126 Can you talk a little more about how this working group will
2127 help hospitals like the ones that I represent meet the health
2128 IT standards?

2129 Dr. {Blumenthal.} Secretary Sebelius, as you know well,
2130 Congressman, was the governor of a rural State so she has
2131 been very interested in the issues that pertain to HIT access
2132 in rural areas. She is convening the secretaries of
2133 commerce, Agriculture, the Veterans Administration and the
2134 chairman of the Federal Communication Commission actually
2135 next week for a first meeting to discuss ways in which we can
2136 work together using the resources of these different
2137 departments to bring to rural communities the resources they
2138 need to be meaningful users of health information technology.
2139 I don't want to presume what is going to come of that
2140 meeting, it hasn't been held yet, but there are broadband
2141 resources available at Commerce and USDA. There are tele-
2142 health resources. The VA does a lot of outreach in its
2143 communities. The FCC spends \$400 million a year on broadband
2144 and communications so we are trying to make sure that between
2145 the Department of Health and Human Services and these other
2146 agencies that we are dedicating all the resources we can to

2147 making up for the differences, the special burdens that rural
2148 communities have.

2149 Mr. {Space.} Thank you, Dr. Blumenthal and Mr. Trenkle.
2150 I yield back my time, my one second.

2151 Mr. {Pallone.} I thank the gentleman and recognize the
2152 gentleman from Connecticut, Mr. Murphy.

2153 Mr. {Murphy of Connecticut.} Thank you very much, Mr.
2154 Chairman. Thank you both for your all your work and for
2155 being here today.

2156 I wanted to build on a question that Chairman Waxman
2157 raised, and let me first pose it to you, Dr. Blumenthal. I
2158 think one of the most exciting pieces of the health care
2159 reform bill is the path forward we have set on the change in
2160 delivery system and the change in which we pay for medicine
2161 to really move from a system in which we today value volume
2162 to a day in which we can place the appropriate value on
2163 outcomes and quality. I am obviously very happy to hear your
2164 emphasis on the connection between health care IT and the day
2165 in which that can happen. I think your response to him was
2166 in regard to accountable care organizations, which I think
2167 will be transformative.

2168 I wanted to ask you about some other potential payment
2169 changes and new models of delivery. One of the pilot
2170 programs that I and others worked very hard on was looking at

2171 new ways to bundle payments in particular with respect to
2172 post-acute care, and in that setting, you are dealing with
2173 complex patients that are coming in and out of hospital and
2174 physician settings, often having some of their most expensive
2175 care in, for instance, skilled nursing facilities. I know we
2176 can't cover everybody with the payments in this law but I
2177 wanted to get your thoughts on how we continue to broaden out
2178 the number of providers that are eligible for these payments,
2179 or in the absence of doing that, how we find a way to get
2180 comprehensive health care information technology to places
2181 like skilled nursing centers so that we can really implement
2182 these payment delivery system changes that we know have the
2183 potential to do some great things.

2184 Dr. {Blumenthal.} Well, in my role as a provider, as a
2185 practitioner, a primary-care practitioner, I am extremely
2186 sympathetic to the need to bring long-term care, home care,
2187 rehab in coordination and get the information from those
2188 sites into the acute care part of the system. As you pointed
2189 out, the law as currently structured does not make incentives
2190 available to those provider settings, and that is a
2191 limitation. It doesn't prevent, though, those institutions
2192 from finding electronic health record technology themselves,
2193 especially if bundled payment arrangements were to make
2194 available some savings that they could get access to and if

2195 having that technology enabled those savings as I am certain
2196 it would.

2197 So I don't think we should forget that the rest of the
2198 health care world continues to march along and that this
2199 technology is really inevitable. It is the way to collect
2200 and use information and it will take over other sectors as
2201 well.

2202 Mr. {Murphy of Connecticut.} I don't know exactly what
2203 the number is but the statistic always given about the very
2204 small number of patients who comprise a very large number of
2205 costs, these are patients that are obviously in and out of
2206 hospital settings and so whether it is through bundled
2207 payments or another way, I do think we have to find a way to
2208 get some help, especially skilled nursing.

2209 Maybe I will ask the question, a little different
2210 version to you, Mr. Trenkle. As HHS is looking at and CMS is
2211 looking at how to implement these new payment methodologies
2212 or these new pilot programs for delivery system change, are
2213 you looking at implementing them on a time schedule that is
2214 consistent with the rollout of health care information
2215 technology and specifically on this change, post-acute-care
2216 bundle payments, are you worried that there will be a lag in
2217 development of good IT systems in skilled nursing facilities
2218 that might present a barrier to that particular pilot

2219 program?

2220 Mr. {Trenkle.} I don't have all the implementation
2221 dates here but I will tell you, we are working closely with
2222 other parts of the agency to ensure that we are coordinating
2223 with the rollout of the health care reform implementation and
2224 the HITECH provisions.

2225 Mr. {Murphy of Connecticut.} One last question, back to
2226 you, Dr. Blumenthal. Talking about certification, the
2227 temporary system that we have set up today, obviously one of
2228 the things you hear a lot about is providers and hospitals
2229 who have been early adopters and who fear that they are going
2230 to be forced to make some expensive and onerous changes going
2231 forward. Do we expect that the certification process will be
2232 only for new technology or do you think we will have existing
2233 technology that might be out there today, it might have been
2234 out there for a period of time certified as well?

2235 Dr. {Blumenthal.} The requirements for certification
2236 are new because the meaningful-use requirements are new, and
2237 we know that frequently technology that is in place, though
2238 it may be beneficial, doesn't meet the standards or the
2239 certification requirements that meaningful use has created.
2240 So we can't assume that technology in place right now is
2241 capable of supporting meaningful and therefore we can't
2242 assume that it is certified. So yes, if you have technology

2243 right now that hasn't been certified under the new
2244 certification process, you will have to get it certified. It
2245 may be quite easy to do that. It may be that you have
2246 technology that is very capable. But we can't assume that,
2247 and we don't want to create the impression for providers that
2248 something they are using now will be capable of meaningful
2249 when it is not.

2250 Mr. {Murphy of Connecticut.} Nothing preventing an
2251 existing system from being stamped as certified as long as it
2252 meets that requirement?

2253 Dr. {Blumenthal.} Absolutely not.

2254 Mr. {Murphy of Connecticut.} Thank you. Again, thank
2255 you for all your work. This is incredibly important. I
2256 appreciate your being here.

2257 Mr. {Pallone.} Thank you, Mr. Murphy. I am going to
2258 recognize myself since I wasn't here earlier.

2259 I assume, and I missed the beginning, that there was
2260 some discussion about meaningful but it is the most or one of
2261 the most controversial aspects of this round of rulemaking,
2262 and demonstrating meaningful use is the key to attaining
2263 eligibility for incentives for Medicare and Medicaid so there
2264 is a lot of interest from provider communities about how
2265 those rules are structured. So I wanted to ask each of you,
2266 first, Mr. Trenkle, you have been criticized for setting the

2267 bar too high for providers to demonstrate meaningful use.
2268 Others have said the agency isn't demanding enough from
2269 providers. I actually haven't heard that one. Please, if
2270 you would explain to the committee how you define the balance
2271 between high standards and reasonable expectations and how
2272 the final rule reflects that balance.

2273 Mr. {Trenkle.} Yes, I would be happy to do that. I
2274 think it is important to point out that the final regulation
2275 reflects a 17-month process. The Recovery Act was passed in
2276 February of 2009. The final rule came out in July of 2010. .
2277 And during that time we convened several committees that as
2278 Dr. Blumenthal mentioned received input from a number of
2279 stakeholders. We had a public comment period of 60 days. We
2280 came out with a notice of proposed rulemaking. We heard back
2281 from the community that a lot of the objectives were too high
2282 so we adjusted in response to the comments. So I think a
2283 combination of all these efforts have led us to what we
2284 believe is a balance between a strategic framework for
2285 promoting future adoption and meaningful use and recognizing
2286 the realities of the infrastructure and the adoption rates
2287 today.

2288 Mr. {Pallone.} I mean, I guess the concern that I hear
2289 is that a lot of providers simply won't meet the bar and then
2290 our efforts are in vain, but at this point you don't feel

2291 that is the case?

2292 Mr. {Trenkle.} Well, I think we heard loudly from the
2293 community that the bar was too high so we have added
2294 flexibility in terms of the objectives. They have a core and
2295 they have a menu set. We lowered some of the thresholds. We
2296 eliminated the administrative transactions and we did a
2297 number of other changes to the meaningful-use requirements
2298 that reflected a need to lower but also maintain a framework
2299 that will propel us towards future stages.

2300 Mr. {Pallone.} All right. Let me ask I guess
2301 essentially the same question of Dr. Blumenthal. from your
2302 experience, do you believe that providers will be able to
2303 meet the meaningful-use criteria laid out in the final rule?

2304 Dr. {Blumenthal.} I believe they will. I believe there
2305 are tens and even hundreds of thousands of physicians who are
2306 already effectively using electronic health records and are
2307 close to meeting meaningful-use criteria. By the way, that
2308 is true of many small hospitals as well, critical-access
2309 hospitals. I have met with them and seen them with my own
2310 eyes. So I think it is quite possible to do this, and the
2311 question will be whether the physicians and hospitals feel
2312 that it is possible and will devote themselves and make the
2313 effort. We have to make sure that the taxpayer was rewarded
2314 with getting real value from these records for the tens of

2315 billions that were in the legislation, but at the same time
2316 we have to make sure that it was achievable, and that is a
2317 balance that we have been trying to find constantly over this
2318 17-month period. We will closely at what the experience is,
2319 try to learn from that experience and see whether we have set
2320 the bar at the right level. So we have done our due
2321 diligence. We have made our best analyses and we are moving
2322 forward from there.

2323 Mr. {Pallone.} I heard some of the members say that
2324 they were concerned about the penalty if someone doesn't move
2325 forward at a certain point with the HIT, but there is also an
2326 exemption. Do you want to address that, Mr. Trenkle, in case
2327 we run into a situation where they are facing the penalty
2328 but--

2329 Mr. {Trenkle.} Yes, I should have mentioned that
2330 earlier, that there is a legislative exemption in case of
2331 hardship on a case-by-case basis, and we will need to define
2332 the criteria for that hardship in future rulemaking.

2333 Mr. {Pallone.} But that is not something you are doing
2334 in this first round, in other words?

2335 Mr. {Trenkle.} No, because the adjustments aren't
2336 scheduled to come in until 2015 so we will be addressing that
2337 in future rulemaking.

2338 Mr. {Pallone.} All right. I know I have got a couple

2339 minutes here. I just wanted to ask, you know, I always get
2340 the questions, Dr. Blumenthal, about the small practices.
2341 The majority of physician practices continue to be small
2342 practices of one or a few physicians and of course, you know,
2343 given the economics today, a lot of them are struggling, and
2344 it is an investment obviously to move towards health IT and
2345 they say it is going to decrease productivity when it is
2346 initially implemented, a lot of things of that nature. What
2347 would you say about that? I mean, the HITECH Act provides \$2
2348 billion to your office but there is also the regional
2349 extension centers and beacon community programs. Is this
2350 going to be some way to help these single practitioners, or
2351 how do you envision that?

2352 Dr. {Blumenthal.} Well, the small practice is the
2353 target of the Regional Extension Center program. That is
2354 where we are focusing our effort because we realize that
2355 those are the practitioners who are going to have the hardest
2356 time and are going to be the least attractive and have the
2357 fewest resources to attract a commercial vendor, a commercial
2358 consulting company or a so-called integrator to help them.
2359 So we are intending to enroll 100,000 small practices through
2360 the Regional Extension Center program in programs to assist
2361 them becoming meaningful users, and I think that is going to
2362 be a big opportunity for small practices, and over time I

2363 think we will learn how to do that better and better and we
2364 will continue to provide that. That is over the first couple
2365 of years. Later on I think we will be able to do more as
2366 time goes on. So they are very much aware of this group and
2367 the practice is changing and younger physicians are much more
2368 adept at adopting these technologies than physicians my age,
2369 and so I think over time this problem is going to largely
2370 take care of itself.

2371 Mr. {Pallone.} All right. Thank you.

2372 The gentleman from Texas, have you been recognized? I
2373 wasn't here earlier. The gentleman is recognized.

2374 Mr. {Gonzalez.} Thank you very much, Mr. Chairman. I
2375 apologize. I have been absent for much of the hearing, but I
2376 do thank the witnesses.

2377 I have a couple of questions. One is going to be more
2378 parochial. I will start with the more general one, and that
2379 is going to be--and first of all, the sources of the
2380 questions come from the medical community, hospitals and such
2381 in my area because my staff is very sensitive to getting
2382 their input, and they say why don't you ask these particular
2383 questions, and they are much better questions than I would
2384 come up with on my own, so I want to make sure that I get
2385 some of the, I guess the verbiage here, the quality
2386 improvement organizations and the proposed rules, and back

2387 home they are saying because of preexisting relationships
2388 with these quality improvement organizations with the
2389 regional extension centers, what do you see prospectively as
2390 those particular right now it may be prime or subcontractors
2391 with individuals in San Antonio--I am from San Antonio--as we
2392 go forward? Will you have some of these same individuals,
2393 organizations playing a role? It seems like it would be a
2394 good idea just because of preexisting relationships and of
2395 course the expertise that they would bring to the table.

2396 Dr. {Blumenthal.} Our regional extension centers, which
2397 is what you are referring to, I think, here were chosen on a
2398 competitive basis. We had many more applications through the
2399 regional extension centers than we were able to fund. I
2400 think about a third, if I am not mistaken, of our regional
2401 extension centers are quality improvement organizations so
2402 that that coincidence, that overlap already exists. Where
2403 are there are not quality improvement organizations, we are
2404 instructing the regional extension centers to work with
2405 quality improvement organizations and with all the other
2406 pertinent organizations in their community.

2407 Mr. {Gonzalez.} The other question, and I don't know
2408 how unique it is to San Antonio but obviously we have a very
2409 large military presence. At the present time we have two
2410 major military hospitals. One actually just closed recently,

2411 Wilford Hall, but BAMC is being plussed up, Wilford Hall will
2412 have a state-of-the-art ambulatory center, and we have a
2413 major VA hospital. The issue that comes up is of course can
2414 they still--will they be able to communicate, the
2415 interoperability issue that comes up, the different
2416 guidelines and requirements that maybe a military hospital or
2417 a VA may be subjected to as opposed to the other hospitals in
2418 San Antonio because there is quite a bit of overlap, believe
2419 it or not, as far as patient care. Your thoughts on that?

2420 Dr. {Blumenthal.} We work very closely with the VA and
2421 DOD to help them achieve seamless interoperability between
2422 their local facilities. As a matter of fact, we prioritize
2423 some beacon communities where there were VA and DOD
2424 facilities that were trying to communicate because we wanted
2425 to support that activity. So one of the ways we are doing
2426 that is by developing software and standards that will work
2427 specifically to facilitate their interoperability so very
2428 much on our radar screen, Congressman, and we hope we can
2429 continue to help them and make this a reality because I know
2430 it is also of great concern to the President that our current
2431 servicemen and our veterans get integrated care that benefits
2432 from all the information that is available about them.

2433 Mr. {Gonzalez.} Well, thank you very much, and I yield
2434 back, Mr. Chairman.

2435 Mr. {Pallone.} Thank you. I want to thank both of you
2436 for your testimony and answering our questions. As I
2437 mentioned before, obviously some members have said they are
2438 going to follow up with written questions as well, but this
2439 is an issue that is hugely important to our hospitals and our
2440 providers, so thanks a lot really for--

2441 Mr. {Shimkus.} Mr. Chairman, will you yield?

2442 Mr. {Pallone.} Sure.

2443 Mr. {Shimkus.} And I would hope that our first panel
2444 would follow the hearing record. On the second panel, we
2445 have seven folks on there. They are from small hospitals.
2446 They are from family practitioners. A lot of these questions
2447 that we have addressed come from them. I know you probably
2448 won't stay, but I would encourage you to get the hearing
2449 record and see some of the issues that have been raised in
2450 the second panel.

2451 Dr. {Blumenthal.} Absolutely.

2452 Mr. {Pallone.} I agree with Mr. Shimkus. Thank you
2453 very much.

2454 Dr. {Blumenthal.} Thank you.

2455 Mr. {Trenkle.} Thank you.

2456 Mr. {Pallone.} And I will ask the second panel to come
2457 forward. Now, we are expecting votes on the Floor fairly
2458 quickly so I doubt we will get through all seven people that

2459 are on the panel but we are going to try to start and get as
2460 far as we can because there are seven of you, I believe.

2461 Well, first of all, let me welcome everyone. I know we
2462 have a large panel here. I am going to introduce each of
2463 you. Beginning on my left is Frank Vozos, Dr. Vozos, who is
2464 Executive Director of Monmouth Medical Center speaking on
2465 behalf of the New Jersey Hospital Association. Thank you for
2466 being here, Frank. Monmouth Medical Center is in my hometown
2467 of Long Branch, and I was actually born there. Next is Mr.
2468 Gregory Starnes, who is CEO of Fayette County Hospital. That
2469 is Fayette County, Georgia?

2470 Mr. {Starnes.} Illinois.

2471 Mr. {Pallone.} Fayette County, Illinois. Okay. Sorry.
2472 And then we have Ms. Christine Bechtel, who is Vice President
2473 of the National Partnership for Women and Families; Dr.
2474 Roland Goertz, who is President-elect of the American Academy
2475 of Family Physicians and CEO and Executive Director of the
2476 Heart of Texas Community Health Center; Dr. Matthew
2477 Winkleman, who is a physician with the Primary Care Group in
2478 Harrisburg, Illinois; Dr. Glen E. Tullman, who is Chief
2479 Executive Office of Allscripts; and Dr. Peggy C. Evans, who
2480 is Director of the Washington and Idaho Regional Extension
2481 Center with Qualis Health.

2482 We ask each of you to limit your testimony to 5 minutes.

2483 You can certainly add additional testimony if you like and
2484 then you will get more written questions from us later, and I
2485 will start with Dr. Vozos.

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2486 ^STATEMENTS OF FRANK J. VOZOS, M.D., FACS, EXECUTIVE
2487 DIRECTOR, MONMOUTH MEDICAL CENTER, ON BEHALF OF NEW JERSEY
2488 HOSPITAL ASSOCIATION; GREGORY D. STARNES, CEO, FAYETTE COUNTY
2489 HOSPITAL; CHRISTINE BECHTEL, VICE PRESIDENT, NATIONAL
2490 PARTNERSHIP FOR WOMEN AND FAMILIES; ROLAND A. GOERTZ, M.D.,
2491 M.B.A., PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY
2492 PHYSICIANS, CEO AND EXECUTIVE DIRECTOR, HEART OF TEXAS
2493 COMMUNITY HEALTH CENTER; MATTHEW WINKLEMAN, M.D., PHYSICIAN,
2494 PRIMARY CARE GROUP, HARRISBURG, ILLINOIS; GLEN E. TULLMAN,
2495 CHIEF EXECUTIVE OFFICER, ALLSCRIPTS; AND PEGGY C. EVANS,
2496 PH.D., CPHIT, DIRECTOR, WASHINGTON AND IDAHO REGIONAL
2497 EXTENSION CENTER, QUALIS HEALTH

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2498 ^STATEMENT OF FRANK J. VOZOS

2499 } Dr. {Vozos.} Good afternoon, Mr. Chairman, Ranking
2500 Member Shimkus and distinguished members of the committee.
2501 Thank you for inviting me to testify today. I am Dr. Frank
2502 Vozos, Executive Director of Monmouth Medical Center located
2503 in Long Branch, New Jersey. Monmouth Medical Center is a
2504 member of the San Barnabas Health Care System, the largest
2505 not-for-profit integrated health care delivery system in New
2506 Jersey and one of the largest in the Nation. I am also here

2507 on behalf of New Jersey Hospital Association.

2508 I am pleased to appear before you today to highlight how
2509 the HITECH Act will support the transformation of Monmouth
2510 Medical Center by helping us successfully fulfill our goals
2511 related to the acquisition and implementation of health
2512 information technology and to applaud the federal government
2513 for establishing a program that will provide incentive
2514 payments through Medicaid and Medicare to doctors and
2515 hospitals who demonstrate meaningful use of the certified EHR
2516 system.

2517 By way of background, Monmouth is a 527-bed community
2518 teaching hospital that provides a full spectrum of services
2519 from neonatology to geriatrics with more than 800 medical and
2520 dental staff members. The medical center admits more than
2521 22,000 adult and pediatric patients and cares for over
2522 120,000 outpatients annually. We are one of the largest and
2523 oldest teaching hospitals in New Jersey and we are the
2524 largest academic affiliate of Drexel University College of
2525 Medicine and that is a relationship that we have had for over
2526 4 years. We are further distinguished among the landscape of
2527 health care providers in New Jersey by our relationship with
2528 the Long Branch federally qualified health center, which
2529 opened in April 2004 and grew directly out of Monmouth
2530 Medical Center's longtime motto of providing primary care to

2531 the community through charity care clinics.

2532 It is important to note that Monmouth is the leading
2533 health care provider in the city of Long Branch, a multi-
2534 ethnic enclave of residents who are disproportionately poor,
2535 young, uninsured and members of minority groups. More than
2536 35 percent of the city's population lives at or below 200
2537 percent of the federal poverty level. There are four census
2538 tracts with the city that have been federally designated as
2539 low-income, medically underserved populations, and although
2540 there are 40 primary care health care providers located in
2541 the area, most do not accept Medicaid or offer charity care.
2542 So as a result, the medically indigent population of Long
2543 Branch and its surrounding communities use the low-income
2544 clinics or our emergency room at Monmouth as their only
2545 source of health care.

2546 While Monmouth was moving fairly well down a path of HIT
2547 adoption before the passage of the HITECH Act, the new law
2548 certainly strengthens our ability to effectively transition
2549 to more comprehensive adoption. I think we have pursued this
2550 goal enthusiastically, embarking on a facility-wide effort to
2551 upgrade our health information technology capabilities on
2552 multiple fronts.

2553 As an example, in our emergency department we have
2554 invested significant resources to install many sophisticated

2555 information technology components including directing the
2556 interface between the emergency room clinical information
2557 system and hospital charts using the EDIMS computer
2558 framework. All records and tests are available of the care
2559 of the patient and it links to our medical center health
2560 information record. Repeating testing unnecessarily has
2561 declined and patient safety combined with more timely care
2562 has been the core outcome of this initiative.

2563 Monmouth Medical Center's clinical information system
2564 suite of products, which is current the Cerner Millennium, is
2565 currently CCHIT certified. These products adhere to
2566 requirements dealing with functionality, security and
2567 interoperability. On a regional level, we are one of the
2568 leaders in developing protocols and an infrastructure to
2569 share clinical data with four medical centers through
2570 Monmouth and Ocean County, and that is regardless of our
2571 competitive marketplace.

2572 One aspect of the new system we are very focused on is
2573 computerized physician order entry. We are dedicating
2574 significant time and effort to changing behavior of
2575 physicians to enter orders into the computer instead of
2576 handwriting them. In a teaching hospital, it becomes
2577 important to leverage that technology infrastructure such as
2578 CPOE as a teaching modality as well as a recordkeeping

2579 modality as the large resident staff interacts most
2580 frequently with the patients and completes written orders.

2581 Moving outward from our emergency department, the extent
2582 of EMR use is varied throughout the rest of the hospital. In
2583 the emergency department, EMR includes medication orders, lab
2584 results, radiology readings, history and physicals, nurse and
2585 physician notes as well as discharge instructions. On the
2586 floors, the EMR has lab results, radiology readings and other
2587 test results and other parts of the record are still
2588 handwritten, although with easy access. So it is part of our
2589 global IT initiative that all areas of the medical center
2590 will be EMR active by 2011.

2591 Further meaningful-use requirements with a compliance
2592 goal of 2011 at Monmouth include provisions for a physician
2593 to take advantage of EHR in their own private practice.
2594 Private physician offices and their style of practice are
2595 being taken into account as vendors are linked with these
2596 clinical partners to create the EMR interface with Monmouth.
2597 By 2011, there will be active physician connectivity with the
2598 hospital. Part of this deliberate strategy includes the
2599 costs associated with linking physicians and the medical
2600 center through EMR. What can be subsidized and what is
2601 funded by the medical center or physicians are important
2602 factors as we work through this connectivity goal. The

2603 ability to eliminate potential errors and medical errors
2604 including handwriting and timeliness of order gives clear
2605 quality markers for both private physician practice and care
2606 provided at Monmouth Medical Center.

2607 In addition, we were recently selected and are currently
2608 actively engaged as one of only two hospitals in New Jersey
2609 to begin a CMS-funded 21-month pilot project to test and
2610 model transitioning Medicaid patients who present to the
2611 emergency department with non-emergent care needs to the
2612 appropriate primary care setting through collaboration with
2613 our federally qualified health center. This data-driven
2614 pilot has further integrated electronic referral systems and
2615 electronic health records through infrastructure enhancements
2616 and a recommendation to the State and federal agencies
2617 administering and coordinating the pilot in New Jersey and in
2618 19 other States. Currently, the FQHC clinicians can
2619 electronically access the hospital record for a previous
2620 hospital history and test results for their patient. By
2621 2011, the new CPOE functionality will be fully interoperable
2622 between the emergency department and the Long Branch
2623 federally qualified health center, allowing for truly
2624 comprehensive EMR for our patients as well as CPOE for our
2625 physicians and other clinicians both in the medical center
2626 and private offices.

2627 Mr. {Pallone.} Frank, I am going to have to ask you to
2628 summarize the rest.

2629 Dr. {Vozos.} Okay. I am done. I just want to let you
2630 know that for the patients in this pilot study, we have seen
2631 a 70 percent conversion rate from people that have been using
2632 the emergency room as their medical home now to the federally
2633 qualified health center as their primary care.

2634 So again, thank you for inviting me. I appreciate this
2635 opportunity to appear before you today and I will answer any
2636 questions.

2637 [The prepared statement of Dr. Vozos follows:]

2638 ***** INSERT 3 *****

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2639 Mr. {Pallone.} Thanks so much, really.

2640 Now, that was the bell. I think we can get at least two
2641 more in, maybe three, before we go vote.

2642 Mr. Starnes.

|
2643 ^STATEMENT OF GREGORY E. STARNES

2644 } Mr. {Starnes.} Chairman Pallone, Ranking Member Shimkus
2645 and other distinguished members of the committee, thank you
2646 for this opportunity. My name is Greg Starnes and I am the
2647 Chief Executive Officer of Fayette County Hospital and Long
2648 Term Care in Vandalia, Illinois. I have been in health care
2649 administration my entire career, and I consider it an honor
2650 to be here today to talk with you about the HITECH Act.

2651 First, please know that my colleagues and I support the
2652 HITECH initiatives. Fayette County Hospital and Long Term I
2653 is a critical-access hospital with 25 beds and 85 long-term
2654 care beds. The facility serves a county of 21,000 people and
2655 resides in the county seat of Vandalia with a population of
2656 7,000. The average household income is below the State
2657 average. The percentage of elderly in the population is
2658 higher than the State average. The unemployment rate is 10.8
2659 percent. The number of Medicaid eligible has increased in
2660 the last year and the numbers of individuals who find
2661 themselves with no ability to pay for health care services
2662 have also risen. They represent the reality in today's rural
2663 health care environment and many parts of Illinois.

2664 The challenges I have faced during the last 18 months

2665 have been the most difficult of my career. In early 2009, my
2666 hospital began to feel the effects of the changing economy.
2667 July of each year has typically been the month during which I
2668 have been able to provide merit pay increases for my
2669 dedicated employees. In May of 2009, I informed my employees
2670 they would not be receiving any wage increases in July. The
2671 hospital finances did not improve in the ensuing months as a
2672 local employer with 140 employees relocated to another State.
2673 In early October 2009, I conducted numerous meetings with all
2674 employees to inform them that I was reducing the work hours
2675 by 5 hours per 2-week pay period, which represented a 5
2676 percent decrease in their wages. My managers and I accepted
2677 a 10 percent reduction in our salaries. I reduced vacation
2678 accruals and temporarily halted the employees' 401(k) match
2679 and I eliminated several positions. We saved a great deal of
2680 month in the fourth quarter of 2009 yet we finished the year
2681 in the red with a net income of a negative \$74,000. On
2682 January 1, I increased the managers' salaries 5 percent.
2683 Since that time there have been no hour or wage increases for
2684 anyone. The number of full-time-equivalent employees in
2685 September of 2009 was 225. The total now is 195. I
2686 represent only one example of many hospitals that have faced
2687 those same challenges, hospitals that are within the top
2688 three employers in the communities we serve.

2689 We are not just about health care in our communities, we
2690 are also about jobs. We are about jobs for nurses, nurse
2691 aids, physicians, lab and X-ray technicians, housekeepers,
2692 cooks, maintenance workers, therapists and so on, and of
2693 course, information technologists. In some of these jobs
2694 categories, there are shortages of qualified personnel. In
2695 all of these categories, these workers need the proper tools
2696 to do their jobs to the best of their abilities. CT
2697 scanners, MRI units, operating room equipment, ambulances, et
2698 cetera are hugely expensive. Software, hardware and training
2699 are extremely cost. To achieve the expectations of our
2700 patients along with those of the governing authorities
2701 requires a great deal of money. Awareness of this among our
2702 Congressmen and Congresswomen is vital as we endeavor to
2703 improve health care in America.

2704 There are 51 critical-access hospitals and another 15
2705 rural hospitals in Illinois out of 200 plus total hospitals.
2706 All are taking steps toward meaningful-use criteria. At
2707 least 10 of the critical-access hospitals have less than 20
2708 days cash on hand because of the impact of increased Medicaid
2709 and self-pay patients. A reasonable estimate would suggest
2710 that roughly half of the hospital have inpatient health
2711 information systems and two-thirds of them have lab and
2712 radiology systems. However, only 20 percent have physicians

2713 using computerized physician order entry. The new
2714 meaningful-use rule with allow other practitioners to enter
2715 orders into the system and that will help but it will also
2716 place additional burdens on the hospital staff.

2717 Thank you for your support of the changes in the final
2718 meaningful-use objectives. Some of them indeed lessen the
2719 burdens for critical-access hospitals to achieve those
2720 objectives. The loosening of the CPOE requirements as well
2721 as inclusion of critical-access hospitals for Medicaid
2722 incentives represent a very positive change from the original
2723 proposed guidelines. That said, the challenges our hospitals
2724 still face should not be underestimated. The capital
2725 necessary to procedure the software and hardware is still
2726 less accessible in today's economy than it was 12 to 18
2727 months ago. In my case, the estimated cost for software and
2728 hardware necessary to achieve meaningful use will likely be
2729 close to \$750,000. There will also be substantial costs
2730 associated with establishing interfaces to enable hospitals
2731 and providers systems to connect. An additional \$50,000 to
2732 \$100,000 will be necessary for training and process changes.
2733 So these numbers are large for my hospital and for many
2734 others.

2735 At this time my hospital needs a new CT scanner for a
2736 minimum of \$350,000 because the one we currently have is 8

2737 years old and increasingly unreliable. We also need to buy a
2738 digital mammography unit for approximately \$350,000 so that
2739 women in the community can take advantage of up-to-date
2740 technology and so that unit can work with an electronic
2741 health records system. There are numerous other needs that
2742 are very expensive, and we all face challenges like that
2743 already, and I know that we face the acquisition
2744 implementation of EHR as well. I believe there may be rural
2745 hospitals that will not meet the imposed timeline under
2746 HITECH.

2747 Additionally, qualified health IT professionals are in
2748 high demand and the supply is currently a problem. So
2749 increased need for them in order for hospitals to achieve the
2750 IT requirements for EHR systems may present real-time and
2751 cost concerns. It is indeed fortunate that there are efforts
2752 underway to boost the health IT workforce through funding for
2753 community colleges. However, the boost might not materialize
2754 in time for hospitals to realize the currently structured
2755 incentives for meaningful use. Failure on the part of some
2756 hospitals to arrive at meaningful-use capabilities could
2757 jeopardize patient safety.

2758 It is my understanding that assistance to overcome these
2759 challenges will be available through the RECs, and I applaud
2760 that effort. However, I am concerned as we have seen through

2761 other federal offices and programs there will not be a
2762 sufficient focus on the challenges--

2763 Mr. {Pallone.} Mr. Starnes, I am going to have to ask
2764 you to summarize the rest, too.

2765 Mr. {Starnes.} All right. Thank you.

2766 My colleagues and I truly want to offer patients the
2767 benefits of a fully functional electronic health record
2768 system. We understand the advantages it can have in reducing
2769 overall costs, duplication and errors while also improving
2770 accountability and patient safety. However, I also want this
2771 committee to understand that rural providers and patients
2772 face unique challenges. A recent survey exemplifies that
2773 only about 30 percent of the critical-access hospitals
2774 nationwide would qualify for stage 1 incentives.

2775 Thank you for this opportunity to offer my testimony. I
2776 look forward to working with you to ensure that all
2777 hospitals, providers, urban and rural, realize the benefits
2778 of electronic health record systems. Thank you.

2779 [The prepared statement of Mr. Starnes follows:]

2780 ***** INSERT 4 *****

|

2781 Mr. {Pallone.} Thank you.

2782 We still have another 6-1/2 minutes, so I am going to

2783 ask Ms. Bechtel to go and then we will break.

|
2784 ^STATEMENT OF CHRISTINE BECHTEL

2785 } Ms. {Bechtel.} Good afternoon, Mr. Chairman,
2786 Congressman Shimkus, Congressman Gonzalez. Thank you for
2787 having me here with you today. I am Christine Bechtel and I
2788 am the Vice President of the National Partnership for Women
2789 and Families. We are a nonprofit consumer advocacy
2790 organization here in D.C., and I was also appointed as a
2791 consumer representative to the Federal Health IT Policy
2792 Committee.

2793 So I am honored to be with you today to discuss the ways
2794 in which meaningful use of information technology will
2795 benefit patients and their families. That said, our
2796 discussion today shouldn't actually be about technology. It
2797 should be about the ways in which changes in health care
2798 payment and delivery can create the kind of truly patient-
2799 centered system that we all envision and that every consumer
2800 deserves. That means designing systems around what patients
2801 say they want and need to improve their own health outcomes,
2802 and what patients want is simple and straightforward. They
2803 want their doctors to talk to each other. They want
2804 information about their conditions. They want providers to
2805 know them well enough to make treatment recommendations that

2806 actually make sense for them and they want their care team to
2807 have the information and support that they need to do the
2808 best job they can. Technology plays a critical role in
2809 delivering this kind of patient-centered care. It cannot be
2810 done right, done well or done consistently without
2811 interconnected health IT, and the regulations issued by the
2812 Administration on meaningful-use lay the groundwork for doing
2813 just that.

2814 I would like to highlight some of the ways that the
2815 meaningful-use program will result in tangible improvements
2816 for patients and families by sharing with you the story of
2817 Susan Crowson, who is a family caregiver from Maryland.
2818 Susan looks after her father, Pop, who has Alzheimer's
2819 disease, heart arrhythmia, prostate problems, low blood
2820 platelets and is susceptible to other infections. He sees a
2821 primary care physician, a cardiologist, a urologist, a
2822 hematologist and a neurologist. Each monitors and treats a
2823 separate problem and yet they don't talk to each other. So
2824 Susan had to build a spreadsheet to keep track of it all.
2825 She leaves copies with each doctor and asks that Pop's
2826 records be sent to his primary care physician and his other
2827 specialists, but it is rarely done. When she takes her dad
2828 for lab tests, she is the one who makes sure that each doctor
2829 gets the results or it just doesn't happen. Pop takes there

2830 prescription drugs, two over-the-counter drugs and vitamins
2831 as well as occasional antibiotic. These drugs are prescribed
2832 by different doctors. When his doctors prescribe a drug,
2833 they actually tell Susan to make sure that she checks with
2834 Pop's other doctors about potential drug interactions.

2835 Susan's situation is common. Millions of patients
2836 struggle to gather and update hundreds of pages of medical
2837 records if they can get them at all, toting them from doctor
2838 to doctor, knowing that no provider is likely to have their
2839 full medical history and test results.

2840 Mr. Chairman, I am confident that we can help Susan and
2841 other patients and families get better care by leveraging the
2842 requirements that are now part of the meaningful-use program.
2843 The new regulations are strong, sensible and patient-
2844 centered. If the members of Pop's team were meaningful users
2845 of EHR today, they would maintain up-to-date problem lists of
2846 his conditions and medications. They would check those lists
2847 for drug-drug interactions and allergies. They would provide
2848 Susan with education resources, summaries of care after every
2849 office visit, reminders about follow-up care and more, and
2850 his care team would also start to develop the ability to
2851 communicate with each other electronically.

2852 Stage 1 of meaningful use also builds the foundation for
2853 overall improvements in the quality, safety and efficiency of

2854 care. For example, it requires the collection of race,
2855 ethnicity, preferred language and gender data so that we can
2856 identify and target health disparities. It asks physician
2857 meaningful users regardless of specialty to focus on
2858 hypertension, smoking and obesity so that we can better
2859 address the public health challenges are driving the increase
2860 in chronic conditions and causing costs to skyrocket, and it
2861 advances an important set of criteria for protecting the
2862 privacy and security of health information.

2863 But our work on meaningful use is not done. Stage 2
2864 should enable the robust, secure exchange of clinical
2865 information across all the providers in settings involved in
2866 the patient's care in compliance with federal and State
2867 privacy laws. Patients and families should have timely,
2868 ongoing access to their health information in a way that is
2869 portable so that they can assemble it in a secure place and
2870 quality measures should assess outcomes, functional status
2871 and patient and caregiver experiences.

2872 Put simply, future criteria should be driven by the goal
2873 of high-patient patient-centered care. It is what Susan
2874 deserves and what all patients deserve. After all, health
2875 care transformation is not about money and it is not about
2876 technology, it is about people and it is about leadership,
2877 and we thank you for yours.

2878 [The prepared statement of Ms. Bechtel follows:]

2879 ***** INSERT 5 *****

|
2880 Mr. {Pallone.} Thank you.

2881 We have three votes which normally takes about half an
2882 hour, so we are going to recess and then we will come back
2883 and hear from the rest of you and then take questions, so the
2884 subcommittee now stands in recess.

2885 [Recess.]

2886 Mr. {Pallone.} The Subcommittee on Health will
2887 reconvene, and we left off with Ms. Bechtel, so Dr. Goertz,
2888 you are next.

|
2889 ^STATEMENT OF ROLAND A. GOERTZ

2890 } Dr. {Goertz.} Thank you, Chairman Pallone and Ranking
2891 Member Shimkus and other members. As you said, I am Dr.
2892 Roland Goertz, President-elect of the American Academy of
2893 Family Physicians and I really am excited about the
2894 opportunity to give you our testimony. As a user of EHR for
2895 nearly 14 years, the CEO of a federally qualified health
2896 center that has won the HIMMS award for EHR use, and a
2897 representative of 94,700 members of the AAFP, many in small-
2898 and medium-sized practices, I believe my perspective and the
2899 AAFP's will be useful, particularly as to how to implement
2900 HIT in small practices, how to serve diverse populations with
2901 its use and how the HITECH subsidies will help them.

2902 Nearly one in four of all office visits is made to
2903 family physicians. We provide more care to America's
2904 underserved and rural populations than any other medical
2905 specialty. Our commitment to improving patient care and
2906 clinical outcomes has long made us supporters of HIT. We
2907 believe that the recent meaningful-use regulations will
2908 support what the AAFP already has been doing for many years.
2909 Our focus has been to ensure that the meaningful-use rules
2910 are achievable by physicians in small- and medium-sized

2911 practices and also improve patient care. Our members want to
2912 accomplish what Congress intends. Fifty-nine percent of our
2913 members currently have electronic health records but their
2914 use of it varies greatly. We need to help the rest purchase
2915 IT, encourage those who have it to become more comprehensive
2916 users of it and have all begin to use it more effectively.
2917 We ask that your committee ensure that the first rounds of
2918 reporting and incentives from CMS be both consistent and
2919 reliable.

2920 Let me talk briefly about my FQHC's experience with HIT.
2921 The mission of FQHCs is to provide health care to those under
2922 200 percent of poverty, which includes Medicaid patients and
2923 those who are dual eligible. Our center serves almost 50,000
2924 people in the Waco-McClellan County area of Texas. That is
2925 about 18 percent of the total population of the county. Our
2926 center has 13 sites, two of which are in rural communities.
2927 I am absolutely convinced that our use of EHR has led to
2928 improved patient care and efficiencies.

2929 Fourteen years ago, a number of our physicians were
2930 uncomfortable with computers. Indeed, some even got cold,
2931 clammy, sweaty hands when they came close to a keyboard. We
2932 also are in a rural area, which is more challenging for
2933 physicians using EHRs. Today, not one of our providers would
2934 return to paper records.

2935 Let me make two general observations about adoption of
2936 HIT. One, physicians coming out of residency today expect to
2937 use HIT and do so almost automatically. The issue of
2938 adoption is a generational one and will resolve over time.
2939 However, we are in the middle of a significant health care
2940 transition and must assist all physicians by supporting the
2941 regional extension programs, beacon communities, medical-home
2942 pilots and dissemination of best practices.

2943 Two, small, solo, rural practices in particular are
2944 short of time and dollars. They are busy focusing on patient
2945 care and operating on small margins. Assisting them is
2946 critical to making HIT work in the United States. As an
2947 example, if your office has a major computer problem, you
2948 have an outside support team to analyze and fix the problem.
2949 I think of the regional extension centers as a comprehensive
2950 support team for small practices. These centers will provide
2951 not only technical assistance but general information when
2952 these small practices need help. Therefore, we ask you to
2953 closely monitor the implementation and resources of the
2954 regional extension program because they are essential to
2955 success of these practices. We strongly support the HITECH
2956 Act incentives. These investments are staged and crucial to
2957 improve quality and cost-effectiveness of patient care.
2958 FQHCs also will need similar support.

2959 Let me conclude by restating three points. Number one,
2960 HIT is critical to improving quality and effectiveness of
2961 patient care; number two, physicians in small rural practices
2962 must receive effective technical support during
2963 implementation and use of HIT; and number three, the HITECH
2964 grants are crucial as physicians make these transformative
2965 changes to their practice.

2966 I thank you again, and I am personally excited about the
2967 potential for improving patient care that the tools of HIT
2968 offer us.

2969 [The prepared statement of Dr. Goertz follows:]

2970 ***** INSERT 6 *****

|

2971 Ms. {Schakowsky.} [Presiding] Thank you, Goertz.

2972 Dr. Winkleman.

|
2973 ^STATEMENT OF MATTHEW WINKLEMAN

2974 } Dr. {Winkleman.} Chairman Pallone, Ranking Member
2975 Shimkus and Congressman Gonzalez, let me begin by thanking
2976 you for the opportunity to provide testimony today. My name
2977 is Matt Winkleman. I am a family physician practicing in
2978 Harrisburg, Illinois. Our community is in rural southern
2979 Illinois and has a population of about 10,000. I practice
2980 full time and I am one of the owners of Primary Care Group in
2981 Harrisburg where we serve patients not only from Harrisburg
2982 but from several surrounding communities and rural counties.
2983 Our practice is a rural health clinic that includes eight
2984 primary care doctors, five mid-level providers and a general
2985 surgeon. In total, the clinic employs around 50 people. I
2986 am honored to share with you today our experience with an
2987 electronic health record and a little bit about it impacts
2988 our practice and the care we provide to our patients.

2989 One of the obstacles many physicians cite in the
2990 decision to employ an electronic record is the initial
2991 upfront cost. Not only is the software, hardware and
2992 necessary infrastructure costly but the process of seeing
2993 patients at least in the initial weeks of transitioning
2994 requires changes in work flow that will likely decrease

2995 efficiency and the number of patients seen. As you are all
2996 aware, under our current reimbursement system, fewer patients
2997 means less added to the bottom line, and as a result, many
2998 physicians calculate they cannot afford the initial financial
2999 investment. This is especially true for physicians like
3000 myself who practice in rural areas where the average payer
3001 mix includes minimum commercial insurance and where profit
3002 margins may already be thin.

3003 Thankfully, the HITECH bill is going to help physicians
3004 address many of the challenges and begin reaping the benefits
3005 of electronic health records. The approach taken within the
3006 legislation to reward utilization and not just purchase was
3007 smart. The regional extension centers will be immensely
3008 useful to small practices without the know-how to feel
3009 comfortable moving to an EHR on their own and the funds going
3010 to develop broadband networks and other infrastructure will
3011 be crucial in eventually allowing us to exchange clinical
3012 information.

3013 The benefits of EHR use, as I said, are significant. At
3014 a time of great uncertainty within the general health care
3015 industry, at least one thing seems clear to me: technology
3016 will have a role in helping us provide the kind of high-
3017 quality, safe, efficient care our patients deserve. On
3018 nearly a daily basis, my EHR helps me avoid prescribing a

3019 medication to a patient because they have an allergy to it,
3020 allows me to print out materials for patients to help them
3021 understand their diagnosis and reminds me to order a
3022 mammogram on a 55-year-old patient who came in only for a
3023 sore throat.

3024 It is not uncommon for me to see patients struggling to
3025 manage six to eight medications, caring for three to four
3026 chronic diseases. Medicine is complex, and the reality is
3027 that even the most astute of clinicians can benefit from the
3028 safety checks provided by an electronic health record.
3029 Furthermore, while the individual patient benefits from the
3030 improved safety that stems from use of an EHR, my practice
3031 has begun to see the benefits to the population as a whole.
3032 With the use of our EHR, we were recently able to generate a
3033 report of all the diabetic patients from the practice's
3034 census who had not received appropriate follow-up and
3035 proactively schedule an office visit to get them back in,
3036 giving them a much greater chance of avoiding the costly
3037 complications that can result from diabetes. Additionally,
3038 after the recently controversy surrounding the diabetes drug
3039 Avandia, we were able to generate a list of all of our
3040 patients receiving this medication within a matter of only
3041 minutes. These types of things would have been nearly
3042 impossible with a paper system.

3043 It is also important to keep in mind, however, that all
3044 of these things I am describing would have been just as
3045 impossible if the information in our EHR such as lab data and
3046 medication history were not included as discrete structured
3047 elements in a database. Had they been scanned copies of
3048 paper reports, the information may as well have been in a
3049 paper chart. There must be standards in place which foster
3050 the use of technology in such a way that it truly benefits
3051 patients and provides the most value to the physicians when
3052 they are making care decisions. For this reason, while I am
3053 not generally an advocate of large-scale government
3054 involvement and government management of health care, I do
3055 think this is an area where focused guidance steering the
3056 medical community is absolutely needed.

3057 In summary, as a rural family physician practicing with
3058 an electronic health record, I have seen the benefit they can
3059 provide by helping improve safety, increase compliance with
3060 recommended preventative care and proactively manage chronic
3061 diseases. My practice is located in a county ranked by a
3062 recent Robert Wood Johnson Foundation study as 98th out of
3063 101 in Illinois with regard to the health of its population
3064 and many of the neighboring counties were also near the
3065 bottom of that list. I am optimized that the meaningful-use
3066 incentives and the work of the regional extension centers can

3067 help providers in rural areas like Harrisburg to begin not
3068 only to take advantage of health information technology but
3069 recognize it as another instrumental tool in the pocket of
3070 their white coats. I am excited about what the future holds
3071 and look forward to the next steps in the process as we move
3072 even further forward in connecting providers to allow the
3073 exchange of health information.

3074 Thank you for the opportunity to provide testimony
3075 today.

3076 [The prepared statement of Dr. Winkleman follows:]

3077 ***** INSERT 7 *****

|

3078 Mr. {Pallone.} Thank you, Dr. Winkleman.

3079 Dr. Tullman.

|
3080 ^STATEMENT OF GLEN E. TULLMAN

3081 } Mr. {Tullman.} Actually I am not a doctor.

3082 Mr. {Pallone.} Mr. Tullman, CEO Tullman.

3083 Mr. {Tullman.} Chairman Pallone, Ranking Member Shimkus

3084 and other distinguished members of the committee, thank for

3085 the opportunity to testify today. My name is Glen Tullman

3086 and I serve as the Chief Executive Officer of Allscripts.

3087 Allscripts is the largest provider of electronic health

3088 records, electronic prescribing, practice management software

3089 and other software that helps physicians manage their

3090 patients. More than 160,000 physicians, which is one-third

3091 of all practicing physicians outside the four walls of the

3092 hospital, use Allscripts software along with 800 hospitals

3093 and over 10,000 other health care providers in post-acute

3094 care facilities and home care agencies to manage their

3095 patients. Allscripts solutions automate daily activities and

3096 connect their clinical and business operations.

3097 It is now 17 months since the passage of the American

3098 Recovery and Reinvestment Act and it is clear that health

3099 care information technology as an industry is forever

3100 changed. It is my belief that we are at the beginning of the

3101 single fastest transformation of a major industry in the

3102 history of our country. Congress and the Administration in a
3103 sign of true leadership have provided an investment in
3104 technology that will lead to the delivery of better care for
3105 all Americans, improve patient safety and deliver significant
3106 savings due to efficiency.

3107 I speak to hundreds of health care professionals every
3108 month across the entire spectrum of care and it is clear from
3109 them that the meaningful-use incentives in the stimulus
3110 package are an essential component of the sea change that
3111 health care is undergoing and that will benefit all of us
3112 today. However, understanding how the stimulus and
3113 meaningful use applies to our clients and how to implement an
3114 electronic health record can be challenging. This is
3115 especially true because our clients span the entire continuum
3116 of care from single physician primary care practices and
3117 rural geographies to federally qualified health centers to
3118 the largest and most prestigious academic medical centers in
3119 the country.

3120 Allscripts have committed extensive resources over the
3121 past 17 months to educating all of these groups, not just our
3122 clients, about meaningful-use incentives. We have hosted
3123 hundreds of free educational sessions across the country and
3124 webcasted many more, and in 2 weeks since the release of the
3125 final rules on July 13th, we have already provided

3126 educational content to thousands of webcast attendees. We
3127 expect our educational efforts to continue as we work closely
3128 with regional extension centers in the coming months and
3129 years.

3130 The HITECH incentives had a measurable stimulative
3131 effort on our business in three ways. First, inquiries about
3132 our electronic health records have been at record levels
3133 since the initial passage of ARRA. Second, we have increased
3134 our annual R&D expenditures a full 25 percent from \$72
3135 million to \$90 million, which will help drive innovation into
3136 the industry. And third, we have hired more than 560 people
3137 since the passing of ARRA with plans to hire several hundred
3138 more in the next year. These are high-paying technology-
3139 centered jobs, just the kind of jobs that the American
3140 workforce needs.

3141 Even more importantly, our clients are also hiring
3142 directly as they work to ensure success in their health care
3143 IT adoption efforts. For example, Denver-based Catholic
3144 Health Care Initiatives, in part spurred by the meaningful-
3145 use incentive program, has announced that they will be hiring
3146 200 health IT professionals over the next year, and we have
3147 many other clients with similar plans. So if you had any
3148 questions, the health care incentive stimulus plan is working
3149 in our industry.

3150 Now, the final rule is out and hospitals and health care
3151 organizations among our client base are very pleased. The
3152 uncertainty about meaningful use has been removed and many of
3153 the changes that the provider community requested during the
3154 comment period were in fact incorporated. This process was a
3155 positive example of a productive public-private partnership.
3156 Many physicians particularly appreciated the flexibility
3157 related to what constitutes meaningful.

3158 You have created real incentive and real momentum with
3159 meaningful and with health care reform efforts. Now I would
3160 encourage you to take three steps to build on that success.
3161 First, push vendors like Allscripts and providers to achieve
3162 even higher standards related to more-robust connectivity.
3163 All systems should be able to connect and accept data from
3164 outside systems as if it were their own by using common
3165 standards as the banking industry does today. Second, it is
3166 time to mandate electronic prescribing. This is a patient
3167 safety issue and one we believe we can address. And finally,
3168 let us continue to focus on performance metrics and use
3169 payment and delivery system reforms to reward physicians who
3170 demonstrate positive outcomes for their patients.

3171 In summary, the final rule on meaningful use will result
3172 not only in a higher number of providers participating in the
3173 incentive program but more importantly higher quality and

3174 safer care for patients. We expect most providers not only
3175 to meet but to exceed the requirements of meaningful use,
3176 which we call meaningful value, by doing more than the
3177 minimum. We have key clients across the country who are
3178 doing just that. For example, the University of South
3179 Florida and Wellspan in Pennsylvania are both using
3180 electronic health records to deliver better diabetes care and
3181 better inform patients. Sharp Healthcare in San Diego is
3182 approaching 90 percent electronic orders. Heritage Valley
3183 Health System in Pittsburgh is writing 100 percent of their
3184 prescriptions electronically and there are a host of others
3185 who are leading the way. We also see leaders like North
3186 Shore Long Island Jewish, Hartford Hospital and the
3187 University of Massachusetts, who are leading the way by
3188 connecting their communities for better care with the goal of
3189 one patient record.

3190 Your actions have served to both encourage and
3191 accelerate all of these activities and to spur other
3192 organizations to take similar actions. As the technology
3193 becomes part of the regular work flow and electronic health
3194 records provide critical information, we will see that
3195 meaningful use is essentially a jumping-off point, ultimately
3196 resulting in the connected system of health that we are all
3197 working towards.

3198 Thank you for all of your efforts and the opportunity to
3199 testify today, and I would be happy along with the panel to
3200 answer your questions. Thank you.

3201 [The prepared statement of Mr. Tullman follows:]

3202 ***** INSERT 8 *****

|

3203 Mr. {Pallone.} Thank you, Mr. Tullman.

3204 Dr. Evans.

|
3205 ^STATEMENT OF PEGGY C. EVANS

3206 } Ms. {Evans.} Thank you. Good afternoon, Mr. Chairman
3207 and members of the subcommittee, thank you for inviting me
3208 here today. I am Peggy Evans, Director of WIREC, the
3209 Washington and Idaho Regional Extension Center for Health
3210 Information Technology. I represent Qualis Health, a private
3211 not-for-profit health care consulting firm and a Medicare
3212 quality improvement organization for the States of Washington
3213 and Idaho. I am honored to be here today to tell you about
3214 how WIREC will provide vendor-neutral EHR adoption services
3215 to help health care providers attain meaningful.

3216 Providers often start their EHR adoption believing that
3217 once the technology has been installed, they are at the end
3218 of their EHR implementation journey. In fact, once
3219 implementation has occurred, the journey has just begun.
3220 Technology is a great tool when it works well, but no matter
3221 how well it works, it is just a tool. Training people to
3222 utilize their technology is an essential component of
3223 successful EHR adoption.

3224 Our initial experience working with providers strongly
3225 indicates that there is a need for EHR technical assistance
3226 service through the REC program. For example, there is a

3227 community health center in the readiness planning stage of
3228 EHR adoption. They received a bid from a commercial, that is
3229 a non-REC, consultant for services at \$225 an hour for a
3230 total bill of \$45 million. The cost of a commercial
3231 consultant was prohibitively expensive for a community health
3232 center and they enrolled in WIREC, thus saving \$45,000 for
3233 support of patient care and other administrative needs.

3234 Another story is that at our first site with another
3235 small clinic, we learned that the practice had not considered
3236 designating a project manager for their EHR implementation
3237 with only six weeks until their go-live date. While EHR
3238 vendors help providers with a bulk of their implementation
3239 and technology needs, providers often need to understand that
3240 there are tasks on their end that should be completed in
3241 order to help them help themselves, which is where WIREC
3242 steps in.

3243 WIREC's program strategy is threefold. First, we
3244 provide on-the-ground health IT coaches that deliver one-on-
3245 one customized technical assistance to providers. Second, we
3246 establish and maintain network IT communities of practice to
3247 share learning. For example, we have implemented an EHR
3248 regional group purchase committee with an independent
3249 consultant who is facilitating the process and committee
3250 members supporting the work. Third, we plan to support peer-

3251 to-peer networking activities that will allow participating
3252 providers to learn from one another, a very powerful method
3253 of communication. Our WIREC staff delivers a suite of
3254 services to providers across the three stages of the EHR
3255 adoption continuum: selection, go live and optimization.
3256 For providers in all stages, we disseminate information about
3257 the CMS incentive payments, help providers understand the
3258 meaningful-use criteria within a framework for reaching that
3259 level of EHR use and provide assistance in workflow
3260 evaluation and redesign.

3261 The importance of workflow redesign cannot be stressed
3262 enough. Many providers are under the assumption that they
3263 will transition from paper to EHRs but continue to use the
3264 same workflow processes that supported their paper-based
3265 records, but if they do that, they are unlikely to succeed
3266 with their EHR adoption. Health IT professionals and
3267 researchers have shown time and time again that workflow
3268 redesign is critical for successful EHR implementation and
3269 that it is not business as usual.

3270 Recognizing that providers in our region may have
3271 already adopted a multitude of EHR systems as a starting
3272 point toward meaningful use, WIREC offers vendor-neutral
3273 services and will work with providers regardless of their
3274 choice in EHR systems. Among the first several hundred

3275 providers who have enrolled with WIREC, they are currently 14
3276 different EHR products already in use which hopefully you can
3277 see displayed on the screen. There you go. I won't take the
3278 time to read them all but you can see that there is a wide
3279 variety of EHRs that we currently support.

3280 Because one of WIREC's major objectives is to assist
3281 providers in meaningfully using their EHR systems, our
3282 consultants help identify the gaps between where the provider
3283 is now and where he or she needs to be in order to reach
3284 meaningful use. We then lay out a customized path for how to
3285 achieve meaningful use. We have received feedback from many
3286 providers that the meaningful-use criteria just seem like a
3287 long list of unorganized requirements. WIREC staff provides
3288 a framework for organizing the criteria in a way that is more
3289 readily digestible by providers and their staff and then
3290 suggest doable chunks that providers can tackle without being
3291 overwhelmed. To date, we have successfully enrolled
3292 practices that represent about 500 primary care providers as
3293 indicated on the map. Among our initial enrollees, there is
3294 a distribution of practice locations across the two-State
3295 region that includes both urban and rural sites.

3296 The REC program focuses on smaller provider offices,
3297 community health centers, rural health clinics and other
3298 ambulatory practices affiliated with the critical-access

3299 hospitals and rural hospitals and providers that primarily
3300 treat the underserved and uninsured. As you can see on the
3301 display graph, a vast majority of our enrolled providers are
3302 from smaller practices. Of the larger practices that we are
3303 serving, mostly all are community health centers or rural
3304 health clinics.

3305 The WIREC consulting team has now begun providing
3306 educational programs and direct assistance in the field to
3307 our participating practices. Initial survey results suggest
3308 that providers find REC services to be valuable. As you see
3309 on the display screen, among our practice sites thus far, 100
3310 percent of the providers have reported satisfaction with
3311 WIREC services. The number of practices surveyed thus far is
3312 small but the results are encouraging.

3313 Additionally, our educational webinar series for
3314 providers has been well received with evaluation responses
3315 showing consistent ratings around 90 percent of respondents
3316 agreeing that each of the sessions has been a value as
3317 indicated again on the display.

3318 In conclusion, Qualis Health's startup experiences show
3319 that providers across our region, both urban and rural, are
3320 enrolling into the WIREC program and initial feedback from
3321 providers shows that they are finding value in working with
3322 the REC program as a supplement to the support that they may

3323 receive from their EHR technology vendor. Implementing an
3324 EHR system and moving toward meaningful use is a
3325 transformation far beyond the technical aspects of
3326 implemented a computer system. WIREC looks forward to
3327 helping providers embark on that transformation through our
3328 vendor-neutral support.

3329 Thank you again for the opportunity to share our
3330 experiences.

3331 [The prepared statement of Ms. Evans follows:]

3332 ***** INSERT 9 *****

|
3333 Mr. {Pallone.} Thank you, Dr. Evans.

3334 We are going to take questions now, and if we don't have
3335 votes, we will do two rounds. I just don't know when the
3336 votes are coming to come. I will start with myself for 5
3337 minutes.

3338 I want to start with Dr. Vozos. One of the most
3339 important functions of health IT is to connect a patient's
3340 doctor and hospitals together across a patient's illness, and
3341 EHR could follow a patient from an outpatient clinic to the
3342 hospital, back home again, facilitating communications and
3343 care along the way, and of course, I am following up on my
3344 visit to Monmouth Medical Center where we discussed this.
3345 You describe how Monmouth is integrating its health records
3346 across settings including with your affiliated federally
3347 qualified health clinics. Just tell us more about how that
3348 project is progressing, and I of course witnessed part of it
3349 when I was there a few weeks ago.

3350 Dr. {Vozos.} Our health system, as you know, was
3351 developed really back in 2004, April 2004, and the reason we
3352 put it together was that though we had a lot of clinics, you
3353 know, we saw that the long-term evolution of those clinics
3354 was going to be a continuing loss of money and plus we had
3355 declining of services to the community in our area there. So

3356 converting that to a federally qualified health center and
3357 also with the reimbursement that was available to a federally
3358 qualified health center, you know, really kind of saved it,
3359 not only saved it, actually grew it to where it is probably
3360 one of the premier health providers in the area. In fact, it
3361 provides pretty good competition to private practitioners.

3362 Mr. {Pallone.} I used an example about one day when I
3363 visited and there was a guy sitting there in a business suit,
3364 which I thought was unusual, but may not anymore.

3365 Dr. {Vozos.} Well, what is a little bit unique about
3366 this particular FQHC is that it was necessary that we
3367 incorporate our teaching programs into the FQHC because the
3368 clinics, as everybody knows, are a major source of teaching
3369 for residency programs so we did incorporate them in, so our
3370 faculty actually are doctors in the clinic and the residents
3371 are also there. So it is a little bit unique, maybe not
3372 quite as efficient as Dr. Winkleman's FQHC or, I mean, Dr.
3373 Goertz's FQHC, but it is an excellent source of care. So it
3374 has grown tremendously.

3375 Mr. {Pallone.} How does the HIT fit in with--

3376 Dr. {Vozos.} What we did was initially we connected
3377 them. It is a one-way connection right now from the FQHC
3378 into our hospital, meaning that they can access all the
3379 record of the patients that are in our hospital that they see

3380 in the clinic, and as you could imagine, most of the patients
3381 in that clinic when they do need to come to the hospital,
3382 they use Monmouth Medical Center or the Monmouth emergency
3383 room. So the physicians of the FQHC have direct access
3384 through the Internet into our--

3385 Mr. {Pallone.} But wasn't there also something where if
3386 you went to the emergency room and they thought that you
3387 could use the services of the community health center, that
3388 they set up an appointment or something for you, right?

3389 Dr. {Vozos.} Well, that is our other pilot program
3390 where, you know, under a grant we--

3391 Mr. {Pallone.} This is the demonstration program?

3392 Dr. {Vozos.} Right.

3393 Mr. {Pallone.} That was my second question.

3394 Dr. {Vozos.} Yes, and that program, what the pilot was
3395 to take all the patients who really were using our emergency
3396 room as their medical home, so to speak, identified those
3397 that really needed to have a primary care provider and
3398 arranged for them to be followed up in our federally
3399 qualified center. We thought initially we could easily make
3400 that happen once but we were kind of curious as to what the
3401 true conversion was going to be where they were not going to
3402 use the FQHC as their private, you know, physician office.
3403 There has been a 70 percent conversion. It has been really a

3404 tremendous success, and what it has done is, it has
3405 decompressed the emergency room, improved the throughput for
3406 the emergency room and really unclogged our emergency room
3407 and created a whole--a much better atmosphere even in our
3408 emergency room.

3409 Mr. {Pallone.} But it also made it possible for the
3410 people that have regular care so they didn't--

3411 Dr. {Vozos.} Well, they now have--

3412 Mr. {Pallone.} --end up just using the emergency room.

3413 Dr. {Vozos.} --a regular physician in the FQHC.

3414 Mr. {Pallone.} Now, is there also a Medicare
3415 demonstration program that looked at whether gain sharing
3416 between hospitals and physicians can reduce cost?

3417 Dr. {Vozos.} Right.

3418 Mr. {Pallone.} And then there was an electronic health
3419 records component of that too?

3420 Dr. {Vozos.} Yes, there is. We are part of a Medicare
3421 demonstration project, which is 12 hospitals in New Jersey,
3422 where we put together a set of criteria with the coordination
3423 of the New Jersey Hospital Association, a set of criteria to
3424 measure quality care, and if in the performance of these
3425 measures there was a savings of money, you know, the federal
3426 government has kind of relaxed itself a little bit and
3427 allowed us to share in those cost savings. So we have

3428 recently gone through the first phase of that where there was
3429 not only the signing up of physicians but we completed the
3430 first 6 months of measuring data, and what we are looking at
3431 right now is length of stay, complications, mortality rates
3432 and readmission rates, and there was--we actually issued the
3433 first set of checks and now we are going through the second
3434 phase of additional enrollment because initially not
3435 everybody wanted to enroll. They either didn't trust the
3436 project, they didn't want to have their name in some file
3437 that the federal government could be steering. There is all
3438 kind of reasons why doctors wouldn't sign up. But after the
3439 first phase of this, not we have had about three times the
3440 number of physicians signing up. So we are going to be well
3441 over 200,000 physicians signed up for this, and it has
3442 actually produced savings.

3443 Mr. {Pallone.} All right. Thanks.

3444 Mr. Shimkus.

3445 Mr. {Shimkus.} Thank you, Mr. Chairman. I have been
3446 writing and scratching notes all over the place, so this may
3447 get really disjointed, which would be very similar to most of
3448 my questions that I ask. But it has been very educational.
3449 I am a very outspoken critic of the stimulus bill but
3450 obviously we can see some future benefits down the line in
3451 this provision.

3452 My first question is, all of the examples of health care
3453 information technology that is being used now, how many have
3454 been deployed based upon stimulus dollars? I mean, there are
3455 a lot of examples of health information technology that have
3456 been talked about. Mr. Tullman, you sell it. Dr. Winkleman,
3457 you are using it. Dr. Vozos, you are using it. How much of
3458 that deployment was based upon taxpayer dollars?

3459 Dr. {Vozos.} I would say at Monmouth the upgrade to the
3460 Cerner Millennium--

3461 Mr. {Shimkus.} Let us talk about stimulus dollars.

3462 Dr. {Vozos.} Right. I mean, we need to do that in
3463 order to be able to qualify at any point for the stimulus
3464 dollars.

3465 Mr. {Shimkus.} So your upgrade was, but your original
3466 deployment was not?

3467 Dr. {Vozos.} No, original deployment was Cerner.

3468 Mr. {Shimkus.} And Dr. Winkleman, I know that none of
3469 yours was done based upon--your practice made the decision on
3470 their own and incurred the capital expense and assumed the
3471 risk.

3472 Dr. {Winkleman.} Yes. I mean, our practice made the
3473 decision to move forward with this several years ago before
3474 there was discussion of money available.

3475 Mr. {Shimkus.} Okay. I just want to put that--I mean,

3476 it is an important thing to be placed on the record. Again,
3477 no one is argue that is not beneficial and that we shouldn't
3478 be all in but I also want to point out that a lot of the
3479 examples being used are people who have done it without
3480 government help and government intervention.

3481 I want to go to the--again, Mr. Tullman, we understand
3482 how this really does benefit your business plan and your
3483 ability to hire a lot of folks because there is a new market
3484 being generated by this government push, which we hope will
3485 provide savings and better recordkeeping and hopefully lower
3486 medical liability costs based upon all those benefits. But
3487 Mr. Starnes from my district, in your opening statement you
3488 made some compelling arguments about the crisis in rural
3489 America of operating a small rural hospital. Can you incur
3490 these costs and provide the continued service?

3491 Mr. {Starnes.} Well, the economic downturn did play a
3492 very devastating role for us, so we have had to make lots of
3493 changes in order to rebound from that. What we find and what
3494 I was commenting about was we do have several capital needs,
3495 you know, diagnostic equipment--

3496 Mr. {Shimkus.} And you would put those above HIT?

3497 Mr. {Starnes.} If I have a person come into the
3498 emergency room and need a CAT scan, I need a reliable CAT
3499 scan machine in order to provide that service, so I have got

3500 to put that just ahead of EHR at this point.

3501 Mr. {Shimkus.} Right, and that does segue into kind of
3502 Dr. Evans' point because I think your testimony mentioned
3503 about how you can be in essence a low-cost consultant for
3504 small rural hospitals and practitioners but you are paid on
3505 the government dole, you are not a private consultant that is
3506 for profit, paying taxes, paying for the office space, paying
3507 properly taxes and other issues because you are part of this
3508 government payout that we are doing, but I am not going to
3509 argue with the help but there is probably some computer
3510 consultants who now, you are the lowest bidder on providing,
3511 you know, consulting services and so they are probably going
3512 to Mr. Tullman trying to find a job over in his sector.

3513 Let me--my time is short. For the two hospitals here,
3514 the CMS actuary stated that about 15 percent of Part A
3515 providers would become unprofitable within 10 years based
3516 upon the new health care law because of lower payments, and
3517 the new health care law cuts \$500 billion from Medicare. Dr.
3518 Vozos, are you going to be one of those 15 percent?

3519 Dr. {Vozos.} If that it all that occurs, yes.

3520 Mr. {Shimkus.} You would be?

3521 Dr. {Vozos.} Of course I would be.

3522 Mr. {Shimkus.} You are a major--

3523 Dr. {Vozos.} I am a major teaching hospital but I am

3524 going to rely on those 32 million or the 1.3 million people
3525 in New Jersey who now have insurance to cover that reduction
3526 in Medicare reimbursement. I have to rely on that.

3527 Mr. {Shimkus.} Well, we can talk about that later on.
3528 And Mr. Starnes, kind of the same question. I am shocked. I
3529 thought you would be saying I can survive it because we are
3530 big.

3531 Now Mr. Starnes.

3532 Mr. {Starnes.} Under the critical-access hospital
3533 designation, then hopefully we will be fine, but it is not
3534 going to be easy for sure. We will have to be lean from--

3535 Mr. {Shimkus.} You are already lean. You already can't
3536 provide needed capital equipment to your hospital.

3537 Mr. {Starnes.} Right. Yes.

3538 Mr. {Shimkus.} Mr. Chairman, my time is expired and I
3539 will yield back.

3540 Mr. {Pallone.} Mr. Gonzalez.

3541 Mr. {Gonzalez.} Thank you very much, Mr. Chairman.

3542 My first question, and it may have been covered in the
3543 absence with the other witnesses and it would have been
3544 appropriate for them, but it is a situation that in San
3545 Antonio the hospitals have made me aware of, and I want to
3546 make sure that I frame the question, that is that the
3547 Medicare incentives to grantees would be based on a CMS

3548 provider number if you have multiple campuses, so if there is
3549 anyone on the panel can explain the consequences of having
3550 one Medicare number but having more than one campus as far as
3551 the incentives and how that would be paid. I don't know if
3552 Doctor, is it Vozos?

3553 Dr. {Vozos.} Yes. I mean, it doesn't affect us because
3554 we have our own Medicare provider number but I can explain to
3555 you how it works. You know, there are hospital systems, let
3556 us say, five hospitals within one system all operating under
3557 one provider number so therefore they are going to get the
3558 stimulus once, not for each of the five hospitals. So
3559 theoretically some of the smaller or more rural hospitals in
3560 that system on a standalone basis would never be able to
3561 probably go through all this.

3562 Mr. {Gonzalez.} Anyone else have an opinion on the
3563 problems that that may present?

3564 Mr. {Starnes.} We just have the one campus and so it
3565 really doesn't apply for us, but I can imagine that it is
3566 going to be devastating for hospitals with several campuses
3567 because each facility is going to have its own separate staff
3568 to be trained and all of those costs that they will incur.

3569 Mr. {Gonzalez.} I understand a rural setting is totally
3570 different from what I have described, and Mister--let us see.
3571 Where is--well, it is Dr. Winkleman. I apologize. Mr.

3572 Shimkus has touched on the cost and how we would go about
3573 assisting. We know about the stimulus money but of course
3574 that is finite and such, but prospectively, as a physician,
3575 how is someone's practice going to afford the technology and
3576 the training? We introduced a bill a couple of years ago and
3577 it was a bipartisan bill. It was never passed, but we had
3578 everything in there. But I want your opinion, anyone on this
3579 panel that could give me an opinion as to the best way to
3580 assist the physicians to make that transition. We could have
3581 grants, a combination of grants. We could have low-interest
3582 loans, guaranteed, or tax credits or tax incentives. Is
3583 there any way that we should rank those or just have them all
3584 available? Anybody?

3585 Dr. {Winkleman.} Well, I think that having money and
3586 grants available to help physicians use electronic records is
3587 a positive thing but ultimately I think even better than that
3588 is that physicians begin to get paid for doing a good job and
3589 that as we start to--that our practice gets transformed by
3590 things like electronic health records, that industry will be
3591 motivated to make a product that works well, they will be
3592 motivated to make a product that produces better care, I am
3593 going to be motivated to use that product to provide better
3594 care, not just intuitively for my patients but because I am
3595 rewarded for it. So I think creating an environment where we

3596 are encouraged to use things like this to improve the quality
3597 helps make that transition make financial sense to a doctor
3598 because when you look at it on paper, sometimes it is a tough
3599 sell. There is a lot of upfront capital cost. There is
3600 initial reductions in productivity. On the long term, there
3601 are gains. I think a lot of practices become more efficient.
3602 They certainly do a better job of billing and coding to get
3603 paid for what they actually do. So I think one of the ways
3604 to do it is to make them make financial sense, and part of
3605 that would involve creating a situation where our
3606 reimbursement is tied to us doing a good job, not just seeing
3607 a volume of patients.

3608 Mr. {Gonzalez.} I think that is built in as far as the
3609 incentives and how we proceed with that and do it right. Of
3610 course, any time you have some positive reinforcement or
3611 reward or whatever you want to call it that encourages that
3612 behavior, there is another way of doing that, and that is
3613 obviously you are penalized for not adopting, for not being
3614 more efficient in the use of the technology, so there is all
3615 sorts of different angles. Of course, we would like to do it
3616 in a positive mode, and I appreciate your testimony today and
3617 I yield back, Mr. Chairman.

3618 Mr. {Pallone.} Thank you. I am going to have a second
3619 round for anyone who would like to participate, and I will

3620 start with myself.

3621 I am going to go back to Dr. Vozos, but I guess any of
3622 you could answer it. When I was--I mean, we asked many of
3623 you to come here today because we knew that you were being
3624 innovative with HIT, you know, before we passed the Recovery
3625 Act and we put in this legislation that we have been
3626 discussing. I mean, the idea at least in my mind was to hear
3627 from those who have sort of been the precursors and did this
3628 before there was any money from the federal government
3629 through the Recovery Act. But I would like to know, because
3630 I know when I went to Monmouth Medical Center that even
3631 though we discussed all the things that we are doing, you
3632 also discussed with me what you could do if you were able to
3633 tap the funds under this legislation. So maybe you should
3634 talk to me a little bit about where you would go from here,
3635 assuming you participated in this program.

3636 Dr. {Vozos.} I mean, we are on the road and we are
3637 making a lot of moves but we are far from there, and it is
3638 going to be a tough journey and an expensive one, so really
3639 funding for us it going to be a big issue going forward. You
3640 know, for Monmouth Medical Center the full-blown HIT system
3641 is going to be about \$19 million over some period of time,
3642 and when I listened to Mr. Starnes talk, I said I want to go
3643 find out where you are buying that one, that \$750,000 one.

3644 So it is a \$19 million project for our system. It is just
3645 shy of \$100 million. So as you can imagine, there needs to
3646 be all type of incentives to be able to spend that kind of
3647 money. Now, there is the return on investment so I would say
3648 right now, you know, we are moving forward on a regular
3649 basis. We still have to install more modules into our system
3650 to be able to get to the level where we are fully operable to
3651 even qualify for the stimulus money and that is what we are
3652 doing right now. So it will change the practice at the
3653 hospital for sure. I mean, it will change even how testing
3654 is done and what the residents are learning and the
3655 efficiency of the hospital but we have a road to go, but
3656 there is a bit team working on it and continues to work on
3657 it. And our big thing is linking the physicians and private
3658 practices and private offices and having a two-way exchange
3659 of information. We want to be able for them to populate the
3660 record in the hospital from what they're doing in the office
3661 but at the same time what is happening with their patients in
3662 the office should be able to go the opposite direction back
3663 into their office records too, so that is why we view as very
3664 important to have very compatible EMRs in the physician
3665 office and at the hospital with the appropriate interfaces
3666 set up, and we are putting a lot of effort into doing that.

3667 Mr. {Pallone.} Maybe I will go to Mr. Tullman because

3668 Dr. Vozos gives me the analysis from the hospital, but what
3669 about you in terms of your systems? I think I said in my
3670 opening statement that currently less than 20 percent of
3671 hospitals and 10 percent of physicians are using electronic
3672 health records, and CMS is saying that they are going to go
3673 to 95 to 100 percent of hospitals and 70 percent of
3674 physicians. How are you going to get there? Are you
3675 prepared, and what are the pitfalls?

3676 Mr. {Tullman.} I think it is a good question. What we
3677 have seen, and you recognized that this panel includes a
3678 number of innovators who have taken those steps, and I
3679 commend Dr. Winkleman and the other physicians and members of
3680 the panel for taking those first steps, but in technology
3681 adoption generally you get the first 20 percent are early
3682 adopters. The next 70 percent are where the real dollars and
3683 the benefits are and they take longer, and so the incentive
3684 program that you have put into place will help us get the
3685 next 70 percent and drive that throughout the rest of the
3686 market. From our perspective, we believe we are ready. We
3687 are investing heavily in making sure that the systems are
3688 easier to use, more easily deployed, and again produce the
3689 kind of measurable results that we need in health care, and I
3690 think the RECs, the regional extension centers, the other
3691 programs that have been designed are going to help us move

3692 that along. There are tremendous employment opportunities.
3693 There is tremendous work to do, and that is not just from the
3694 vendors, that is from actually the medical centers across the
3695 country.

3696 You know, the one thing I would say in terms of a
3697 recommendation that we were asked about before is, I think
3698 there is an opportunity to open the program even further to
3699 rural providers who in some cases are excluded because they
3700 are not off the same revenue schedules and to certain other
3701 programs like Medicare Advantage where some of our leading
3702 clients like Sharp Healthcare in California in fact have
3703 problems in terms of getting their physicians covered to use
3704 that, and they cover a significant amount, but overall, we
3705 think we are ready and we think the country is ready for
3706 better health care.

3707 Mr. {Pallone.} All right. Thank you, Mr. Tullman.

3708 Mr. Shimkus.

3709 Mr. {Shimkus.} Thank you, Mr. Chairman.

3710 Mr. Starnes, do you know, what is your closest REC? do
3711 you know it?

3712 Mr. {Starnes.} It is Northern Illinois University.

3713 Mr. {Shimkus.} And that is located where? DeKalb?

3714 Mr. {Starnes.} Yes.

3715 Mr. {Shimkus.} And how far is DeKalb from Vandalia?

3716 Mr. {Starnes.} I couldn't tell you. Somebody else?

3717 Mr. {Shimkus.} Four and a half, five hours.

3718 Mr. {Starnes.} Okay.

3719 Mr. {Shimkus.} I know Idaho-Washington is a big area
3720 too, so, I mean, it is just a point I wanted to raise.

3721 If we follow up on the chairman's point, Mr. Tullman,
3722 about trying to get those numbers of 75 percent to 90
3723 percent, that is really a rush for obviously a population
3724 that you and the other 12, 15 providers--Dr. Evans, you had
3725 that list up, I don't know how many there were, 12, 15
3726 providers who provide the same type of services as Mr.
3727 Tullman. Are we concerned that they will go to the bigger
3728 institutions prior to the smaller ones?

3729 Mr. {Tullman.} We really--I will take the first shot at
3730 that. We believe and what we are seeing is accelerated
3731 adoption across the board, so we know that at least until the
3732 stimulus package, the larger organizations were in fact
3733 advantages because they had CIOs, they had a capital budget
3734 and the like. What the stimulus program does it open it up
3735 so smaller physician groups and offices and independent
3736 physicians can do that. That is number one. Number two, a
3737 lot of the larger organizations, for example, I mentioned
3738 North Shore Long Island Jewish, what they have done is, they
3739 not only bought licenses for their 1,200 employed physicians

3740 but they have actually extended that offer to 7,000
3741 affiliated physicians in the community to help connect them
3742 up and bring those benefits. The last point is that many of
3743 the vendors have come out with innovative programs like a
3744 financing program with no payments for 6 months to help
3745 bridge the gap until smaller providers actually get the
3746 stimulus funding. So I think you are seeing a lot of
3747 innovation.

3748 Mr. {Shimkus.} And I appreciate that. My time is short
3749 and I don't mean to be disrespectful but I think that is
3750 going to be an interesting case study to follow to make sure
3751 that happens. There are just in the broadband world, the
3752 other committee I serve on is Telecommunications. There are
3753 still communities on dial-up. There are still communities
3754 not--and one of our attacks on the stimulus bill is they are
3755 overbuilding broadband areas and not deploying to what we
3756 call unserved areas. Well, Dr. Evans, you probably know
3757 that. Probably in Idaho and the eastern part of Washington
3758 State, there are unserved areas. So the stimulus on the
3759 other end has to get broadband out so everyone can take
3760 advantage of this.

3761 I got a chance to visit with Dr. Winkleman earlier
3762 today, and he brought up this issue that even though he is--
3763 and I have to do this before I do that. I am sorry. Two

3764 letters, I ask for unanimous consent, and one is a compelling
3765 argument of a community of 15,000--Mr. Starnes would know--
3766 Washington County Hospital, Nancy Newby, president and CEO, a
3767 population of 15,000. They are on HIT already and did the
3768 risk, did the same thing. So there are folks who realize the
3769 importance of this and did it previous to the government
3770 intervening.

3771 In the HITECH Act, incentives are based on charges under
3772 the Medicare fee schedule or a provider can qualify for more
3773 than 30 percent of their volume is from Medicaid patients.
3774 As a rural health clinic, will you meet either of these
3775 criteria?

3776 Dr. {Winkleman.} We will have a very hard time
3777 achieving the standard under the--well, let me back up. We
3778 will be very close under the Medicaid, the arm of being 30
3779 percent. Our problem under the Medicare arm is that since
3780 our reimbursement comes via the rural health clinic system
3781 and not directly from Medicare. Our charges to the Medicare
3782 fee schedule are very limited. The only thing we bill to
3783 Medicare fee schedule under fee-for-service are some
3784 ancillary things. So we really don't have a Medicare option
3785 despite the fact that we see a good percentage of Medicare
3786 patients. You know, we really are limited to the Medicaid
3787 option. And so for some of my partners--it would be

3788 different for me, I do family medicine where a see a good
3789 portion of children and a lot of them are Medicaid, but some
3790 of my partners that do primarily internal medicine, primary
3791 care and see mostly adults, a lot of those patients are
3792 Medicare and then they could be sort of left out in the cold.
3793 Seeing a large number of Medicare patients, having adopted
3794 EHR, using them meaningfully, and yet we don't really have
3795 the Medicare charges per se technically that qualifies under
3796 the incentive.

3797 Mr. {Shimkus.} Thank you, Mr. Chairman. My time is
3798 expired but I want to note Dr. Evans was nodding yes, I think
3799 and I guess she would agree with pretty much of that
3800 analysis.

3801 Ms. {Evans.} Yes, and actually we have heard the same
3802 concern from many of the rural health clinic providers that
3803 we have been talking to that they are shut out because they
3804 may not--they basically bill via a bundled mechanism rather
3805 than the provider fee schedule so that leaves them out of
3806 Medicare, and then they don't see the 30 percent patient
3807 panel required for Medicaid or 20 percent of their
3808 pediatricians. So they are really very much interested in
3809 how CMS is going to address the fact that there may be no
3810 incentive payments coming to them.

3811 Mr. {Shimkus.} Well, hopefully CMS is paying rapt

3812 attention to this hearing and that is part of the record.

3813 We haven't talked about HIPAA implications. We haven't
3814 talked about the whole privacy debate. That is really
3815 critical when data is flowing, and I am not smart enough to
3816 go into, Mr. Chairman, so I yield back.

3817 Mr. {Pallone.} Thank you. Mr. Shimkus has asked
3818 unanimous consent to enter these two documents into the
3819 record. Without objection, so ordered.

3820 [The information follows:]

3821 ***** COMMITTEE INSERT *****

|
3822 Mr. {Pallone.} Mr. Gonzalez.

3823 Mr. {Gonzalez.} Thank you, Mr. Chairman.

3824 This question will go to Dr. Evans. Has it been your
3825 experience--now, my understanding is, you are vendor neutral.
3826 That means when you go on site, the hardware has been
3827 purchased, the software. The system is in place, you just--I
3828 am going to read something to you. I am almost embarrassed,
3829 Mr. Chairman, and I am hoping Mr. Shimkus is not listening as
3830 to my sources of information.

3831 Mr. {Shimkus.} I usually don't.

3832 Mr. {Gonzalez.} That is an understatement. But anyway,
3833 this is Hilda Gorito of Kaiser Permanente: ``If you give a
3834 lumberjack who has been using an ax his whole life a chainsaw
3835 and he starts hacking at a tree with it, it is not going to
3836 help him at all. It is what you do with the technology that
3837 makes the difference.'' So you go there, and so now the
3838 physician who used to be a lumberjack now has the chainsaw,
3839 and you are going to teach him basically how to use that
3840 effectively about the technology. When you go on site, are
3841 you discovering that many times--I don't know how to put
3842 this--they have overpurchased? One size doesn't fit all, and
3843 my experience has been with my friends who are physicians and
3844 a couple of friends who actually sell the systems that a lot

3845 of physicians really are not--because you are coming after
3846 the fact, that prior to the purchase of what is a very
3847 expensive investment that it is not done many times with the
3848 knowledge. And Mr. Tullman, I want you to chime in as soon
3849 as Ms. Evans finishes. Where does a physician or a small
3850 practice get the direction and the advice to purchase only
3851 that which they really need and to make an investment and not
3852 realize the return that they could?

3853 Ms. {Evans.} Well, my experience in doing some of the
3854 consulting out in the field is that many times providers
3855 purchase something and then underutilize the system for a
3856 variety of reasons. I can't really speak to whether they
3857 have overpurchased, but what I have seen is that there are
3858 many functions and features that are available to them,
3859 particularly for reaching meaningful use, that they haven't
3860 even necessarily looked at or they don't know exist. And so
3861 we go into the practice to educate them about some of the
3862 availability of the features and functionality as well as
3863 determine the workflow by which they might be able to use the
3864 system in a more effective manner.

3865 Mr. {Gonzalez.} Your thoughts, Mr. Tullman?

3866 Mr. {Tullman.} Yes, I think I would concur, and we
3867 think the largest problem, most significant problem is
3868 underutilization, and that would be true in most pieces of

3869 software that people buy. They tend to use them not at the
3870 maximum but the minimum, so we think the RECs are a good
3871 idea. We also are seeing more and more physicians get
3872 counseling from a variety of ratings services so as a vendor
3873 we are evaluated by a number of different organizations and
3874 of course CCHIT, there are minimum requirements, so there
3875 used to be about 300 different electronic health record
3876 providers. Last year under CCHIT to meet the minimum
3877 standards, that 300, only 70 qualified as meeting the minimum
3878 requirements. Those requirements are now even greater and
3879 will continue to get greater, and we think that is a good
3880 thing. We think that it improves the value of the products.

3881 But your point I think is very important, and that is,
3882 and we believe it is one reason this legislation made sense
3883 and that was you weren't simply buying physicians electronic
3884 health records, you were saying we will help pay for them if
3885 you use them, and that is really the critical aspect of
3886 meaningful use, which we are very supportive of.

3887 Mr. {Gonzalez.} Last question. I have a minute. Ms.
3888 Bechtel, you represent the consumer and such, and I am one of
3889 those that just believe that a patient goes in there
3890 believing that the doctor is up to date on the latest
3891 literature, continuing education, has the best equipment and
3892 so on. Do you believe that HIT should be part of that

3893 equation, that each patient should expect that that
3894 particular physician have that electronic medical records and
3895 the efficiency, effectiveness and cost savings that it should
3896 bring?

3897 Ms. {Evans.} I do, and I think it is interesting
3898 because there are a number of consumers who see technology in
3899 every other sector in this country and assume that their
3900 physicians have it as well, but then they experience the
3901 acute challenge of trying to communicate with the care team,
3902 trying to coordinate their own health care, understanding
3903 that doctors just aren't talking to each other fully and in
3904 the way they could be without interoperable health IT and so
3905 we have done actually a fair amount of research with
3906 consumers directly to understand what do they think about
3907 information technology and the reasons that it appeals to
3908 them are exactly those but they get that it will begin to
3909 reduce the burden that they face, particularly around care
3910 coordination. So we would be delighted to start to see
3911 consumers asking their physicians are you a meaningful user
3912 of information technology, do you have an electronic health
3913 record. I know that when I chose my own doctor recently, it
3914 took me several months to find out that has an electronic
3915 health record, and I did, but to the point of this hearing,
3916 the practice actually doesn't use it in a meaningful way

3917 whatsoever. They really just actually automated paper. So I
3918 think the conversation has to start with, do you have an
3919 electronic health record, but it can't end there. It has to
3920 be, how are you giving me access to my health information,
3921 how are you sending me reminders, how are you summarizing my
3922 care for me and other benefits of technology.

3923 Mr. {Gonzalez.} Well, I thank all of you for your
3924 testimony. I yield back, Mr. Chairman.

3925 Mr. {Pallone.} Thank you. That concludes our
3926 questions, so we want to thank all of you for spending all of
3927 your time here today, and obviously this is very helpful and
3928 it is probably just the beginning of what we are going to
3929 have to look at in dealing with HIT.

3930 The way the rules work, you will get some written
3931 questions from members. We try to have them to you within 10
3932 days, and then of course we ask you to respond as quickly as
3933 you can, and if you want to submit testimony, you can. But
3934 thank you very much. I really appreciate it.

3935 Without objection, this meeting of the subcommittee is
3936 adjourned.

3937 [Whereupon, at 5:30 p.m., the Subcommittee was
3938 adjourned.]