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

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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WITNESSES

SUBMITTED MATERIAL

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

TUESDAY, JULY 27, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

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

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

Staff present: Ruth Katz, Chief Public Health Counsel; Purvee Kempf, Counsel; Katie Campbell, Professional Staff Member; Emily Gibbons, Professional Staff Member; Tim Gronniger, Professional Staff Member; Virgil Miler, Professional Staff Member; Alvin Banks, Special Assistant; Ryan Long, Minority Counsel; Clay Alspach, Minority Counsel; Sean Hayes, Minority Counsel; Brandon Clark, Minority Professional Staff; and Garrett Golding, Minority Legislative Analyst.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I call the meeting of the Health Subcommittee to order.

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

The HITECH Act contained unprecedented funding to promote the adoption of health information technology among hospitals, doctors and health care providers through initiatives by the Office of the National Coordinator of HHS and through Medicare and Medicaid incentives. This historic investment will serve to modernize

our Nation's use of technology to truly ensure a high-performing 21st century system.

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

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

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

Now, it is timely that we have this hearing today, in my opinion, since CMS just announced on July 13th the final rule for the minimum requirements that eligible Medicare and Medicaid providers must meet through their use of a certified electronic health record technology to quality for the incentive payments included in the HITECH Act. This rule was dually released with companion final regulations on the standards and certification criteria needed for EHR technology to be successfully used by eligible professionals and hospitals.

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

I will note we have two great panels of government and private witnesses here with us today. I am particularly pleased that Dr. Frank Vozos, the Executive Director of my hometown hospital, Monmouth Medical Center, can be with us today. I had the opportunity to tour Monmouth Medical Center, which is a community teaching hospital, over the, I guess it was the July 4th recess or work period, and I was very pleased to see the work they are doing already to implement HIT adoption and to learn how they plan to use HITECH funds and guidelines to further advance their medical care, so I want to thank Frank Vozos, another Frank, for being with us here today.

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

[The prepared statement of Mr. Pallone follows:]

Statement of Chairman Frank Pallone
Hearing on Implementation of HITECH Act
July 27, 2010

The Health Information Technology for Economic and Clinical Health Act of 2009 contained unprecedented funding to promote the adoption of health information technology among hospitals, doctors and health care providers through initiatives by the Office of the National Coordinator at HHS, and through Medicare and Medicaid incentives. This historic investment will serve to modernize our nation's use of technology to truly ensure a high performing 21st Century health system.

The Energy & Commerce committee has worked on a bi-partisan, collaborative basis for many years on health information technology. This hearing will examine the progress made so far, and opportunities that will be realized in the future, through the implementation of the HITECH Act.

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The successful adoption of health information technology will have a transformative effect on the quality of health care in the United States. The provisions of the HITECH Act will ensure that Americans nationwide have access to a truly patient centered health care system, with better quality, more affordable health care, delivered in an efficient and coordinated manner. It will promote the advanced use of electronic health records to facilitate the

ordering of tests and medications, aid in clinical decision making, and allow for secure data sharing, and privacy protection among providers, insurers, and patients.

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our witnesses today, as well as on other aspects of the HITECH Act.

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And now a statement from our Ranking Member, Mr. Shimkus.

Mr. PALLONE. With that, I will ask Mr. Shimkus to give us an opening statement.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

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

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

The hearing today is a chance for us to review where we stand and ask ourselves if we are trying to make providers run before they can walk when it comes to HIT. I particularly want to thank a few of our witnesses for being here today from my district back in Illinois. First, Mr. Gregory Starnes is here from Fayette County Hospital, which is a critical-access hospital. Mr. Starnes lends a voice to rural hospitals and the unique challenges they face in trying to implement their systems without the budget and attention of some larger urban hospitals. I also want to thank Dr. Matt Winkleman from Harrisburg, Illinois, for making the trip here today, and of course everyone knows Harrisburg, Illinois—and that is supposed to be a joke. My staffer is fired. That is a good joke. It is all in the delivery, he says.

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

Despite the promising future the HITECH Act holds, it is difficult to look past the failures of the so-called stimulus bill it was part of. The American people paid the tab on what they were told would create jobs, keeping unemployment at below 8 percent and to stimulate the economy. The country has lost over 3 million jobs since the stimulus passed and unemployment hovers at 9.5 percent, even higher in my district in Illinois, all this at a cost of $1.2 trillion to the American taxpayer, an enormous failed policy continued with the health reform law. We have been in session 15 weeks since the health care bill was signed into law by the President in March, 15 weeks and 15 hearings on health, not on the law. In what is likely our last hearing before recess, the majority has never responded to numerous requests to hold hearings on implementation of the new law. On several occasions we have asked for the Administration to come before the committee, to no avail. Yet with ease we were able to have representatives of both HHS and CMS to discuss the HITECH Act today, and we appreciate them coming.

It has been over four months and the majority won't even acknowledge problems exist with the new law and they aren't going away. According to CBO, premiums in the individual market are

going to increase 10 to 13 percent as a direct result of this law. Nearly all small businesses will see no relief from the tax credit in the law. Many small businesses will opt to pay fines rather than buy health insurance because they can't afford the cost. Instead, they will raise prices to customers and stop hiring new employees. High-risk pools that were supposed to provide immediate coverage uninsurable are going to have to have waiting lines and use pre-existing conditions to limit those who enter the new pools. We were told the President's Executive Order would prevent federal dollars from being spent on abortion services yet we already know in Pennsylvania and New Mexico, millions of new federal dollars will go toward coverage of abortion services through their high-risk pools. The President promised the pro-life community and pro-life Democrats in the House his executive order would prevent this from happening. Will the President now make good on the promise or is this evidence of what many of us feared all along, that the health reform law lacks critical protections to prevent taxpayer-subsidized abortions.

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

We have a responsibility to hold hearings on the implementation of the new health care law just as we are doing here today when it comes to the HITECH Act. Madam Chairman, with the law that will touch every American life, I hope we will at least have an explanation for the majority to the American people on why this request is being ignored, and I yield back the balance of my time.

Mrs. CAPPS [presiding]. The Chair recognizes herself for an opening statement.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

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

I hope that today we will be able to explore the implementation of the HITECH Act to date including both the successes as well as the challenges that have been encountered, but I also hope to dis-

cuss the future implementation steps of this bill as our Nation's health care system moves from paper-based recordkeeping to a dynamic electronic system. The promise of health information technology for both patients and providers is, I believe, remarkable, and as the public understands how it is so beneficial, it is going to make a difference in the way we accept the changes in health care that will come about as we see that they are very cost-effective.

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

So I look forward to the testimony of our witnesses and I yield back.

At this time I will recognize Mr. Gingrey for an opening statement.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Madam Chair, thank you so much.

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

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

Madam Chair, if there were silver bullet solutions for our health care system, information technology would surely be one of them, maybe the main one. This technology has the potential to improve

the quality and the efficiency of our health care system while ensuring that tax dollars are spent wisely. With it, we can better identify and we can cut waste, fraud and abuse out of the system. Once implemented, we will be better able to protect patients' privacy and eliminate the inefficiency of a system based on paper charts. I know of what I speak. I practiced medicine for 31 years.

Therefore, a series of targeted bills based on silver bullets, medical liability reform, increased transparency, electronic medical records, health insurance reform for sick and low-income Americans could have passed in a transparent and bipartisan manner. Instead, what did we do? We passed a 2,400 page omnibus bill that few members could read and understand. Madam Chair, I have repeatedly used my opening statement in this committee over the past few months to support my ranking member, John Shimkus's call for a hearing on Obamacare, Patient Protection and Affordable Care Act of 2010. Why? Well, because on March 9th, Speaker Pelosi said that the bill is, and I am going to quote her now, "going to be very, very exciting but we have to pass the bill so you can find out what is in it away from the fog of controversy." Now, that is a direct quote. Speaker Pelosi was successful and this Democratic majority did pass Obamacare, but the fog of controversy still exists in spite of her promise. It turns out that a large majority of workers won't be able to keep the health care they like today and they may even lose their jobs because of the law. The cost projections for patients, employers and our government continue to rise. Health insurance will not be available or affordable to hundreds of thousands of sick Americans. These problems all represent broken promises made by the President to the American people. Where the President's rhetoric has not lived up to his product, Congress indeed needs to investigate. The American people deserve to know what is in this law, and I fear that unless we hold hearings immediately to investigate the new law, our constituents will find out the hard way.

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

Mrs. CAPPS. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Mr. GINGREY. And I yield back. Thank you so much, Madam Speaker.

Mrs. CAPPS. The Chair now recognizes Ms. Schakowsky for 5 minutes—for 3 minutes.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Madam Speaker.

I just want to respond briefly to the ranking member, who rather than addressing the potential for reducing costs and improving care of health IT decided as usual to restate the talking points of the insurance industry including saying that this historic and impor-

tant piece of legislation is the cause of higher costs. Instead, what we have seen is excessive premium increases—see Well Point—and higher profits—see United Health Care, who at the same time as their profits went up the amount of health care they actually provide for each dollar has gone down. And a part of this bill is talking about the advantages that we can reap from taking advantage of health IT, which is vital for this country.

The development of a nationwide interoperable health information technology system is a critical component of improving health care quality, promoting care coordination and reducing medical errors. I have been in the record rooms of clinics and hospitals, rooms overflowing with files taking up space that could be put to significantly better use. These clinics need health IT, and the $2 billion provided in the American Recovery and Reinvestment Act will go a long way to upgrade and improve this Nation's health care system. As someone who recognizes the substantial rewards of moving our health care system toward health IT functions, I also know that we must ensure complete security and privacy for consumers.

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

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

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

Mrs. CAPPS. The Chair now recognizes Mr. Pitts for his opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Thank you, Madam Chairman.

On February 17, 2009, the President signed the American Recovery and Reinvestment Act, also known as the stimulus bill, into law, promising that the $787 billion bill would create or save 3½ million jobs over the next 2 years. We were also told that the stimulus would hold unemployment under 8 percent. At this point in the recovery, unemployment would be at 7.5 percent. No one, not the White House, not Congressional leadership, can tell us with any degree of accuracy how many jobs have been saved or created. In fact, it is impossible to calculate how many jobs were not lost due to the passage of the stimulus or any other bill, for that mat-

ter. As for jobs created, we have an ever-expanding federal workforce, not a thriving private sector, and as we all know, unemployment is currently at 9.5 percent after peaking at 9.9 percent earlier this year.

One of the provisions included in the stimulus was the Health Information Technology for Economic and Clinical Health, or HITECH Act. While I would question how the HITECH Act is stimulative or how many jobs it has saved or created, we all see the promise of health information technology from reduced errors, greater efficiencies to being able to share information across the country with the click of a mouse, and I support the goals of the HITECH Act. Many of us have been contacted, however, by providers from back home who panicked when the proposed rule came out earlier this year, and it seemed that few hospitals and doctors' offices could meet such an aggressive implementation timetable or stringent criteria.

I hope that our Administration witnesses will discuss how the final rule has been changed to address some of these concerns, and I look forward to hearing from our witnesses. Thank you, Madam Chairman. I yield back.

Mrs. CAPPS. The Chair now recognizes Ms. Eshoo for her opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Madam Chairwoman. It is nice to see you in the chair, and thank you for holding this important hearing on the implementation of the HITECH Act.

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

I have been concerned for a long time about this issue. I introduced comprehensive legislation, HIT legislation, in 2007. We spent months meeting with doctors, with hospitals, with technology companies, which I think everyone knows, many of them make their home in my Congressional district, as well as HIT vendors, and I am proud to say that the work that my staff and myself did on that legislation really became the basis of the legislation that Mr. Dingell introduced and now we are going to be reviewing it.

So I am really pleased that Dr. Blumenthal, the National Coordinator for HIT, and Anthony Trenkle from the Office of E–Health at CMS are going to share with us their experiences in implementing the legislation. I know that there are bumps in the road. There always are. When constituents ask me about legislation, I al-

ways say well, understand that legislation is shaped by human beings and that legislation bears the mark of humanity. It is less than perfect. But what is exciting to me is that we have launched the effort. We have placed significant resources next to it, $2 billion, and so today is a good chance to hear about how we are doing on this very important journey. So I look forward to hearing from our friends that are here to be witnesses and also to the second panel that will instruct us as well.

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

Mrs. CAPPS. I thank my colleague.

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

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

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

Obviously the Republicans are not against health information technology. Last year we worked on a bipartisan basis to pass a bipartisan health IT bill. Unfortunately, that bill did not become law. Instead, at the start of this Congress, our friends in the majority passed their version of health IT as part of the so-called stimulus bill. I would like to hear from the witnesses later this afternoon just how stimulative that has been. The unemployment rate is about 9½ percent around the country. This bill that we are looking at today didn't do much in the private sector. It focused more on spending federal dollars while ignoring the less-expensive avenues for health IT deployment. I think it would have been better to allow hospitals and physicians to donate health IT systems to each other, for example. It has been over a year since this bill became law, the stimulus bill, that is. That package is going to cost about $1½ trillion. Numbers that I have been given indicate that according to the Bureau of Labor Statistics, we have lost over 3 million jobs in that time, so I think it is a fair question: where are these jobs and how has this particular bill helped create jobs.

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

So in any event, Madam Chairman, again, we are not opposed to health IT, we are not opposed to the federal government being

involved, but we didn't have much say in this particular bill, so it is going to be an interesting dialog as we go forward.

With that, I will put the rest of my statement in the record. And again, we do thank our witnesses and we look forward to their testimony. Thank you.

[The prepared statement of Mr. Barton follows:]

Opening Statement
Honorable Ranking Member Joe Barton
Subcommittee on Health
Hearing on Health IT Implementation
Tuesday, July 27, 2010

Mr. Chairman, I would like to welcome the witnesses to the hearing, and thank them for testifying today.

This committee has been focused on Health Information Technology years, including last year, when we worked on a bipartisan basis to pass health IT legislation. Unfortunately, it did not reach the finish line.

At the start of this Congress, the majority passed health IT provisions as part of their so-called stimulus bill. I look forward to hearing from the witnesses on how the health IT provisions of the stimulus legislation are being

implemented, and whether they have created the many new jobs that were promised by the administration. As the unemployment rate remains at 9.5 percent across the nation, it seems like the president's stimulus legislation was less than even marginally successful.

I am also disappointed that the majority's health IT bill focused solely on spending federal tax dollars while ignoring less expensive avenues for health IT deployment. Congress should have clarified the law to allow hospitals and physicians to donate health IT systems to each other.

It has been a well over a year since the stimulus was passed, and it is clear to the American people that it is a colossal failure. The stimulus will cost the American people a total of $1.2 trillion, and there is little evidence

that it has achieved much of anything other than spending money we don't have.

According to the Bureau of Labor Statistics, this country has lost 3.42 million jobs since the stimulus passed. As Americans are asking "where are the jobs?" It is clear that the majority has nothing to offer.

Similar to the stimulus, the new health law appears on its way to failure. We continue to ask for hearing on the new law, but the Majority refuses. Just last week, I wrote a letter to Chairman Waxman, asking for a hearing on the appointment of Dr. Berwick as the Administrator of CMS, who was recess appointed.

The President's surprise decision to avoid normal public examination of this nominee is just another cause for concern compounding the hear daily problems arising in the implementation of Obama's health care law. Dr. Berwick has now taken an important job without Congressional approval. The American people do not even know how Dr. Berwick intends to implement the new law. Congress and the people have every right to know how Dr. Berwick will implement the $575.1 billion in Medicare cuts before he begins the cutting. People have a right to know how Dr. Berwick will cut $145 billion from the Medicare Advantage program. We have a right to know who will lose their plans because of his decisions.

Dr. Berwick also will be in charge of implementing an unprecedented expansion of the Medicaid welfare program.

The misguided law expands enrollment in this welfare program to more than 90 million people, with an increase in spending of nearly 90% during the 2014-2019 period alone. The unjustifiable Medicaid expansion is just another example of how this law will actually increase the growth in health care spending, not decrease it like we were promised. Dr. Berwick and the Obama Administration owe the country an explanation of what they're up to.

Dr. Berwick's previous public statements suggest that he believes that the government should be the final arbiter on what the medical care patients can get and how much they can have. Put another way, the new head of Medicare thinks that rationing is a legitimate function of government-supervised health care. Given the power of the Medicare and Medicaid administrator and the concern regarding Dr.

Berwick's extreme opinions, this Committee ought to invite Dr. Berwick to testify at the earliest opportunity so he can speak for himself. He can confirm the news reports or, if his views have been misreported, he can clear the air. We need to know the direction Dr. Berwick intends to take his new agency and our nation's health care system.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mrs. CAPPS. Thank you, Mr. Barton.

And now we turn to Mrs. Christensen for her opening statement.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

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

The Health Information Technology for Economic and Clinical Health Act holds out great promise for improving medical care, and although a few would disagree, reducing health care costs in the future. But I also want to make sure that it eliminates disparities, not exacerbate them. I appreciate the response of the public comments on what constitutes meaningful use, but if some of the big guys like Partners in Health Care, Kaiser Permanente and others have concerns about being able to meet the standards, certainly the smaller, poorer, understaffed, overworked providers will definitely have problems. I can imagine that OMC has in balancing the need to get this implemented, ensuring privacy and bringing all providers in. On the other hand, I know the challenge of providers like I was would have getting this implemented while trying to take care of patients. We will be looking to the regional extension centers like the one at the University of Ponce in Puerto Rico with the Virgin Islands Medical Institute for their help in getting this done. Dr. Blumenthal, in your testimony you say that we should look at this not as investments in technology per se but as efforts to improve the health of Americans and the performance of their health care system, and of course key to improving the health of all Americans is to ensure that those who are disproportionately affected by health inequities are able to access and take full advantage of the provisions of the HITECH Act.

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

Mrs. CAPPS. The Chair now recognizes Mr. Burgess for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the Chair for the recognition. Welcome to our witnesses. We are grateful that you are here. I am grateful that our committee is exercising proper oversight to see if the HITECH provisions of the stimulus bill are being implemented as intended. After all, the United States Congress put $20 billion on the table with the goal of increasing and ultimately achieving universal electronic medical record adoption.

For the record, I did not support the stimulus bill and I continue to believe that some of the provisions relating to health information technology contained within that bill have actually been inhibitory toward their adoption. I am still uncertain whether providing financial incentives such as grants will be effective. I continue to be-

lieve that claims-based incentives ultimately make more business sense.

In addition, our lack of addressing safe-harbor issues is a flaw, and early in an early iteration of a health IT bill, H.R. 1031, I introduced such a concept but unfortunately it was not part of the language that was adopted by the majority when the stimulus bill was passed. I would also like to be certain that new federal guidelines are working in coordination with the quality improvement initiatives that many in the industry are already undertaking and certainly not work at cross purposes to those efforts.

We need to focus on implementation. Even if I didn't agree on how, I am committed to ensuring that the taxpayer dollars are now used responsibly to establish the goal that was set forth. Even if $1 doesn't go out the door, penalties for providers are coming no matter what, and guess what? They are coming pretty darn fast. They will be here in just a couple of years. I have been committed to see that the rules set up by the federal government encourage adoption and allow providers to avoid the proverbial sword of Damocles hanging over the head of every doctor and every hospital in the country in just a few short years. I have certainly been fearful that federal regulations might bog down the normal and routine medical treatment by requirements that are unnecessary and that I imagine both patients and doctors will have some difficulty with complying. Unfortunately, the draft regulations put out in February were, in a word, unworkable. I authorized with representatives Space, Stearns and Engel a letter pointing out several issues with the proposed rule. These were so intuitively obvious that 250 Members of Congress agreed to sign on to the letter. Dr. Blumenthal, to his credit, has always taken my calls, always listened to my concerns and did address many of the issues that were raised. I do remain concerned about the multi-campus issue which has been mentioned and on certification of existing systems as qualified to receive incentive payments, and Madam Chairwoman, I would like to insert into the record a statement by the Premier Health Care Alliance addressing that issue.

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

Mrs. CAPPS. Hearing no objection, the Chair will insert the letter that is recommended by the gentleman.

[The information appears at the conclusion of the hearing.]

Mrs. CAPPS. And now turning to Mr. Sarbanes for an opening statement.

OPENING STATEMENT OF HON. JOHN P. SARBANES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. SARBANES. Thank you, Madam Chair. I look forward to the testimony from the witnesses today.

The search for the tipping point on health information technology has sort of been for some like the search for the Holy Grail. I don't

think when we get there that is what it will turn out to be but I do think it is going to make a huge difference, first for patients and then for the costs of the system in terms of reducing cost, promoting more efficiency and so forth.

I always have every head in the room nod when I talk to an audience about how frustrating it is when a patient goes to a provider and has to have the baseline medical record recreated for them because it is so difficult for the provider to put their hands on tests and other records that have been done and are available out there somewhere but they somehow can't get hold of those, the result being that the patient is then subjected to more tests, more pushing and prodding when that information that we give the provider a baseline picture of the person's health and condition is available, it is just not at their fingertips. And HIT has the potential to solve that problem. When it does so, it is going to make a tremendous advance forward for patient care and obviously, as I said, improve efficiency and reduce cost.

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

Mrs. CAPPS. The Chair now recognizes Mrs. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Madam Chairman, and we do welcome our guests and we thank you for being here.

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

I think that everyone is concerned with this deadline of January 1, 2011. We will have some questions about that because that is the time for provides to have in place a certified EHR to qualify for those Medicare health IT incentive programs, and between now and then our providers and vendors are going to have to ramp up very quickly. I will say, Madam Chairman, I think that when Congress does not engage in putting some of these items in statute and leaves it to agencies to put in place, we see unworkability and having to do some revisits. It also appears that CMS had lowered the bar in some areas in the recent rule while remaining overly prescriptive in others. An example, Tennessee hospitals are extremely concerned about the financial implications on multi-campus hospitals that share a single Medicare provider number. That is another area we will want to discuss with you today.

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

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

I thank you for the time. I yield back.

Mrs. CAPPS. The Chair is now pleased to recognize the chairman emeritus of the full committee, Mr. Dingell, for his opening remarks.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Madam Chairman, thank you, and thank you for holding this important hearing.

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

These resources will put us on the path to a more coordinated health care system, which is why the topic of health information technology has long been a focus of this committee. I would like to note that not only has this committee spent many years studying and legislating on the matter but that we have done so in a bipartisan fashion. For example, in the last Congress, this committee passed the bipartisan health information technology bill, H.R. 6357, the Protecting Records, Optimizing Treatment and Easing Communication through Health Care Technology Act of 2008. This bill included language to codify the Office of National Coordinator for Health IT and to provide grants designed to stimulate the spread of HIT. It also included strong privacy protections. This bill became the basis for the HITECH Act.

The Administration recently issued rules, final in character, to support meaningful use of electronic health records. I am delighted that the Office of National Coordination for Health IT and Centers for Medicare and Medicaid Service have worked with all interested parties to develop standards that are attainable but also propel our

health technology systems forward. They have had to thread a very fine needle, and overall they have done a commendable job. However, we all understand that a few concerns remain. I am confident the Administration will continue to hear and respond to the legitimate concerns. I am also aware that the work of the Congress may not be totally done on this issue.

I want to thank both of the panels of our witnesses today for joining us and look forward to their updates on the implementation process. We will find that the testimony today will be in front of a group of people that has a real interest in ensuring that HITECH Act moves forward in a way that fulfills the intent of the legislation.

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

Mrs. CAPPS. The Chair is pleased to recognize for an opening statement Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

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

One of the initiatives that I am most proud of was made possible by the HITECH Act included in the Recovery Act and it is the Paper-Free Florida Collaborative Regional Extension Center. In April, Paper-Free Florida was awarded nearly $6 million for its initiative developed by the University of South Florida in my district. It is one of more than 70 regional extension centers authorized by the Office of National Coordinator. I notice that Glen Tullman from Allscripts is here. He gave us great advice and encouragement from the get-go, so I am glad you are here, Glen. Paper-Free Florida will effectively implement electronic health records in more than 1,000 priority clinical practices, and I heard from the other side of the aisle where are the jobs. Well, I am grateful that a number of the jobs are right in my hometown in Tampa because what we are going to be able to do is recruit and train and employ over 100 e-health ambassadors as HIT extension agents in 20 countries. We are going to avoid costly medical errors for patients, and you should have seen the young doctors when we made the announcement. They are already there. They know this technology and they just can't wait to get started, and it is exactly what we intended by the Recovery Act, creating these high-wage jobs that communities like mine need in this economic downturn. So thank you.

While I am proud that one of the many success stories made possible by the HITECH Act comes from my community, there are a few roadblocks that we need to address to ensure that more health care providers are able to coordinate care, and one area of improvement I think I am hearing consensus across the board here is the meaningful-use rules, and I think you for granting additional flexibility as you took comments from folks and providers all across the country, but we have more work to do here. Dr. Blumenthal, you

have worked hard to make sure that certain entities that are eligible for HIT incentive payments are going to be eligible, but as many of the members today mentioned, the hospital systems with multiple campuses remain in a tough spot under these new rules. And I was with a chief medical officer in Florida for a big hospital system yesterday, they were singing your praises, but this is giving them real heartburn. The decision to allow only one payment per provider number, even if that provider number is used for more than one facility, puts multi-campus hospitals at a real disadvantage. Meanwhile, they have great potential to deliver results, the results that we need.

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

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

Mrs. CAPPS. The next opening statement will be by Mr. Green.

Mr. GREEN. Thank you, Madam Chairman. Before I begin I would like to ask unanimous consent to include a written statement for the record. This is written testimony of Dan Hawkins of the National Association of Community Health Centers.

Mrs. CAPPS. Hearing no objection, so ordered.

[The information was unavailable at the time of printing.]

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

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

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

We are all aware of the benefits improved IT will bring the health care sector and the patients it serves. If implemented correctly, health IT will improve patient safety and garner cost savings. That is why I am glad we are having the hearing today to discuss the status and the implementation of the HITECH Act. As we know, no legislation is perfect and Congress has a history of revisiting legislation many years after its passage. The HITECH Act is no exception. I am particularly interested in discussing potential changes that need to be made to assist community health centers and mental health providers adopt health IT.

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

With regard to mental health providers, I sponsored the Community Mental Health Services Improvement Act for many years. This legislation contains funding for the establishment of grant programs to improve health IT for mental health providers. I recently began working with Representative Patrick Kennedy and Representative Tim Murphy on H.R. 5040, the Health Information Technology Extension for Behavioral Health Services Act, which would amend HITECH to give mental health providers, substance-abuse providers and psychiatric hospitals in parity with other health care providers for medical use of health information technology and electronic health. This legislation clarifies the definition of health care provider to include mental health professionals, substance-abuse professionals, psychiatric hospitals, behavioral mental health clinic and substance-abuse treatment facilities. The legislation requires HHS through the National Coordination of Health Insurance Technology to award grants for mental health treatment facilities not eligible for meaningful-use incentives through the HITECH Act. The grants would allow for purchase of certified electronic records training of medical staff and the use of electronic records and improve the exchange of health information between mental health providers and other health care providers. I am hopeful these issues can be discussed in the future the community health centers and mental health providers are an integral part of our health care system.

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

Mrs. CAPPS. Thank you.

Mr. Murphy is now recognized for his opening statement.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY OF PENNSYLVANIA. Thank you, Madam Chairman.

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

These incentives no doubt are going to increase participation but as I have heard from many doctors and hospitals in my district, that initial requirement for incentive payments seems to be too complex and unobtainable. Now with CMS cutting back on the scope of HIT mandates, it has given providers more time to adopt

records that will collect essential patient data, and I look forward to hearing what providers can do before being financially penalized for noncompliance.

HIT will be an essential component of medicine, or as Dr. David Blumenthal has put it aptly, as accepted in the daily lives of health professionals as the stethoscope and the exam table. Well said. Health IT is most valuable when it is available to providers across all disciplines, and as it advances, we want to make sure government is not a barrier but a team member to work better, effectively, efficiently and economically.

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

Second, we need to be thinking about the overall health of an individual. Unfortunately, the incentives exclude mental health providers. As my colleague, Mr. Green, said, Congressman Patrick Kennedy and I have put in a bill, the HITECH Extension for Behavioral Health Services, H.R. 5040, to make mental health providers eligible for the federal incentive payments. This is a critical bill, and it would extend Medicare and Medicaid reimbursements for meaningful use of electronic health records to mental health professionals across a spectrum.

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

With that, I yield back.

Mrs. CAPPS. Thank you, Mr. Murphy.

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

OPENING STATEMENT OF HON. ZACHARY T. SPACE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. SPACE. Thank you, Madam Chairman.

Thank you for holding the hearing on an issue that of considerable important to all of us. When it comes to health IT, there does seam to be a great deal of agreement on both sides of the aisle with very good cause. Both Democrats and Republicans, providers and consumer groups by and large seem to agree that improving the adoption of health information technology around the country will

be beneficial to the practice of medicine, reduce redundancies, save money, provide a safer environment for patients and I certainly include myself in this support. How we achieve the adequate adoption of health IT is what has brought us here today. Ensuring that every hospital, doctor and clinic in this country have high-quality record systems that ensure patient safety is not an easy task and there is no simple answer to how we reach that destination.

The HITECH Act included as part of H.R. 1 earlier this year offers a promising framework for accomplishing this goal, establishing an Office of the National Coordinator and developing a structure for incentive payments has created a framework for pushing the adoption of health IT in a strategic and meaningful way. However, the meaningful-use rule provided by CMS 2 weeks ago holds some troubling provisions that I fear may steer us away from adoption, and I would like to touch on two of those issues today. First, the multi-campus issue that was brought up earlier I think during Mr. Burgess's statement. I believe firmly that it was the intent of this body in passing the HITECH Act to ensure that each hospital would be entitled to its own incentive payments. The rule offered by CMS denies those payments to hospitals that have chosen to structure themselves with multiple campuses under a single provider number, and I am disappointed in this decision, particularly after we worked with Representatives Burgess, Engel and Stearns to send a letter to CMS that was signed by 240 members of this body. My staff will continue to work with those members and their staffs along with the staff of this committee and the Ways and Means Committee so that this issue can be resolved.

And the second concern we have is what this rule will mean for smaller rural hospitals, like the 13 that we have in Ohio's 18th Congressional district. Most of those hospitals, indeed, all of those hospitals, see an exceptionally high caseload of Medicare and Medicaid recipients with an ever-growing number of self-pay cases. That is a euphemistic term for charitable cases. We see these cases increasing with the economy. For these hospitals, investing in the needed capital to purchase health IT systems that meet the criteria spelled out today is especially challenging. Even with the promise of incentive payments, these investments are costly and difficult. I still have concerns about what these requirements will mean for our hospitals and I certainly hope to learn more about how HHS and CMS intend to help small rural hospitals in accessing this vital technology.

Thank you, Madam Chair.

Mrs. CAPPS. Thank you.

The Chair recognizes Mr. Barrow for an opening statement.

OPENING STATEMENT OF HON. JOHN BARROW, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. BARROW. I thank the Chair for the opportunity to explore this topic.

In getting ready for this hearing, I reached out to some of the folks on the ground back in my district and some of the folks who represent them up here, and there still seem to be a lot of unknowns and unanswered questions out there. We spent a lot of time poring over legislative language and debating the definitions

of legislative terminology. I would like to bring to the attention of the committee some of the more fundamental challenges that I am talking about.

I represent areas that don't even have access to reliable broadband services. I represent counties that are at least an hour's drive away from the nearest IT professional. I am concerned that even if we do everything right up here, we make grant funding available, we offer technical guidance, we provide reasonable rewards for proper implementation, many providers out there are still going to be left behind because we still don't have the proper technological infrastructure in place to take full advantage of this. So my concern is that we make great leaps forward in all other kinds of places with information technology that we don't forget those folks who are still struggling to get on board the IT bandwagon in the first place, and I hope that can be addressed in the course of the hearing.

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

Mrs. CAPPS. Ms. Harman, the Chair recognizes you for an opening statement.

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

Mrs. CAPPS. Absolutely.

OPENING STATEMENT OF HON. JANE HARMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. HARMAN. Most of our colleagues have described what is in this legislation, which is absolutely essential. I just wanted to add a couple of things that haven't been said. One is that a firm in my district makes dog tags, electronic health dog tags for soldiers, and has had some success in selling these to the Pentagon. I have no idea, and probably others would know better than I, whether these could have a civilian application, but the notion that a soldier hit on the battlefield would have all of his health records in this tiny little chip that he wears around his neck is an exciting idea and it might really be useful to people who for any number of reasons could get into problems and urgently need one health provider to be able to download their history. There would obviously be some notion of choice here. I don't assume everyone would be compelled to wear these things, but I just put it out there as something that I think may have promise.

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

And I congratulate this committee for legislating on a bipartisan basis in an area that is absolutely critical to the quality and cost

of health care for Americans including school kids who go to excellent school nurses like our friend Lois.

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

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

Dr. Blumenthal, you may begin your testimony.

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

STATEMENT OF DAVID BLUMENTHAL

Dr. BLUMENTHAL. Chairwoman Capps, Ranking Member Shimkus, distinguished subcommittee members, thank you for the opportunity to submit testimony on behalf of the Department of Health and Human Services regarding the implementation of the Health Information Technology for Economic and Clinical Health Act.

The provisions of the HITECH Act are best understood not as investments in technology per se but as efforts to improve the health of Americans and the performance of their health care system. Three interdependent rulemakings were required to implement the provisions of the HITECH Act generally and the Medicare and Medicaid EHR incentive programs in particular. The first rulemaking establishes the requirements that eligible health care providers will need to satisfy in order to qualify for incentive payments. The second specifies the technical capabilities and standards that certified EHR technology will need to include to support these health care providers, and the third creates the processes for EHR technology to be tested and certified, thus providing confidence and assurance to eligible health care providers that certify the EHR technology they adopt will perform as expected.

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

With the adoption of these three rules, attention now turns to their implementation. The ONC, the Office of the National Coordinator, is now ramping up the development of other processes that will need to be in place to enhance interoperability. Many of these processes will be components of a comprehensive standards and interoperability framework developed by the Office of the National Coordinate to expedite standards harmonization as well as their adoption and use.

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

ONC has engaged in a number of cross-cutting activities related to administering the provisions of the HITECH Act. The major program investment established to date with the $2 billion appropriated to ONC under ARRA include the Health Technology Extension program, the State Health Information Exchange Cooperative Agreement program, the Beacon Community Cooperative Agreement program, the Health IT Workforce program, and the Strategic Health IT Advanced Research Projects program.

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

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

The Beacon Community Cooperative Agreement program provides certain communities with funding to build and strengthen their health IT infrastructure and health information exchange capabilities. These communities will demonstrate the vision of a future where hospitals, clinicians and patients are meaningful users of health information technology and together the community

achieves measurable improvements in health care quality, safety, efficiency and population health.

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

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

[The prepared statement of Dr. Blumenthal follows:]

Testimony Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act

Statement of

David Blumenthal, M.D., M.P.P.

National Coordinator,
Office of the National Coordinator for Health IT
U.S. Department of Health and Human Services

July 27, 2010

Chairman Pallone, Ranking Member Shimkus, distinguished Subcommittee members, thank you for the opportunity to submit testimony on behalf of the Department of Health and Human Services (HHS) regarding the implementation of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) passed as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

The passage of the HITECH Act represents an historic and unparalleled investment in health information technology (HIT). This investment lays the groundwork necessary to pursue the President's goals related to improved health care quality and efficiency and will help transform the way health care is both practiced and delivered. Broad use of HIT has the potential to improve health care quality, prevent medical errors, increase the efficiency of care provision and reduce unnecessary health care costs, increase administrative efficiencies, decrease paperwork, expand access to affordable care, and improve population health.

Implementing the HITECH Act

The provisions of the HITECH Act are best understood not as investments in technology *per se*, but as efforts to improve the health of Americans and the performance of their health care system. They are specifically designed to work together to provide the necessary assistance and technical support to providers, enable coordination and alignment within and among states, establish connectivity to the public health community in case of emergencies, and assure that the workforce is properly trained and equipped to be meaningful users of certified electronic health records (EHRs). Combined, these programs build the foundation for every American to benefit from an EHR, as part of a modernized, interconnected, and vastly improved system of care delivery.

The HITECH Act essentially laid out four objectives for HHS: 1) to define the meaningful use of certified EHR technology; 2) to encourage and support the attainment of meaningful use through incentive payments and grant programs; 3) to bolster trust in electronic IT systems through ensuring privacy and security; and 4) to foster continued HIT innovation.

The HIT Policy and Standards Committees

The HITECH Act established two new Federal Advisory Committees, the HIT Policy Committee and the HIT Standards Committee, from which I regularly seek advice and recommendations in implementing the provisions of the HITECH Act. Formed a little over one year ago, these two committees have already contributed a great deal to our activities. The HIT Policy Committee played a critical role in the process of defining meaningful use Stage 1. The HIT Standards Committee played an equally important role in recommending an initial set of HIT standards and implementation specifications for adoption by HHS and in support of meaningful use.

Both Committees have created several workgroups to tackle the many challenging issues for which we seek expertise, wisdom, and advice. These workgroups focus on making recommendations to the two full committees related to: meaningful use; certification and adoption; health information exchange; strategic planning; privacy and security; enrollment; and standards for clinical operations as well as clinical quality activities.

As we pursue the ambitious agenda set forth by the HITECH Act, we are acutely aware that it is paramount to implement appropriate policies to keep electronic health information private and secure. Privacy and security form the bedrock necessary to build trust, which is essential to achieve the vision outlined. Patients and providers must feel confident in the processes and policies in place related to HIT and the electronic exchange of health information.

Thus, to ensure that we have timely privacy and security recommendations related to the HITECH programs for which we are responsible, the HIT Policy Committee formed an interdisciplinary "Tiger Team" of experts comprised of members from both the HIT Policy and Standards Committees as well as members from the National Committee on Vital and Health Statistics (NCVHS). The Tiger Team is currently focused on addressing the priority privacy and security issues identified by the State Health Information Exchange Cooperative Agreement Program, the Regional Extension Centers (RECs), and Nationwide Health Information Network programs.

The Tiger Team is expected to make recommendations to the HIT Policy Committee shortly on: 1) consent, in particular, whether individuals should be allowed to choose whether to participate in the exchange of data through health information organizations; 2) data segmentation technologies that protect information an individual may deem sensitive from disclosure; and 3) the privacy and security requirements for participants in health information exchange activities who are not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. Once the Policy Committee receives the Tiger Team's input and issues its recommendations, we anticipate finding ways to incorporate, where appropriate, such recommendations into our programs. For example, the RECs may be able to incorporate new training information on best practices for health care providers they support.

The Office of the National Coordinator for Health Information Technology (ONC) is further working with the President's Cybersecurity Coordinator, Mr. Howard Schmidt, as well as the President's Chief Technology Officer, Mr. Aneesh Chopra, and Chief Information Officer, Mr. Vivek Kundra, to identify best practices for improving the security of EHRs. Our

meaningful use rule requires that users of certified EHRs perform a security risk assessment and correct any deficiencies detected.

Meaningful Use of Certified EHR Technology

Three interdependent rulemakings were required to implement the Medicare and Medicaid EHR Incentive Programs. The first rulemaking establishes the requirements that eligible health care providers will need to satisfy in order to qualify for incentive payments. The second specifies the technical capabilities and standards that certified EHR technology will need to include to support these health care providers. And the third creates the processes for EHR technology to be tested and certified, thus providing confidence and assurance to eligible health care providers that the certified EHR technology they adopt will perform as expected.

On July 13th, with the issuance of the Medicare and Medicaid EHR Incentive Programs final rule and the Initial Set of Standards, Implementation Specifications, and Certification Criteria final rule, a 17-month effort was capped to publish the three rulemakings necessary to implement meaningful use Stage 1. These rules, cumulatively, reflect the over 2,000 public comments from stakeholders across the health care system, and illuminate the initial pathway to achieving an integrated and electronically connected health care system.

During this time, and in response to public comments, ONC and the Centers for Medicare & Medicaid Services (CMS) worked collaboratively to strike a balance between acknowledging the urgency of adopting EHRs to improve our health care system and recognizing the challenges that adoption will pose to health care providers. Our approach to meaningful use must be both ambitious and achievable. Like an escalator, HITECH attempts to move the health system upward toward improved quality and effectiveness in health care. But the speed of ascent must

be calibrated to reflect both the capacities of providers who face a multitude of real-world challenges and the maturity of the technology itself.

The Initial Set of Standards, Implementation Specifications, and Certification Criteria Final Rule

In this final rule, the Secretary completes the adoption of an initial set of standards, implementation specifications, and certification criteria, to align such standards, implementation specifications, and certification criteria with final meaningful use Stage 1 objectives and measures. The adopted certification criteria establish the required capabilities and specify the related standards and implementation specifications that certified EHR technology will need to include to, at a minimum, support the achievement of meaningful use Stage 1 by health care providers under the Medicare and Medicaid EHR Incentive Programs. EHR technology must be tested and certified according to the adopted certification criteria to ensure proper incorporation and usage of the adopted standards and implementation specifications, and thus compliance with the adopted certification criteria. The standards, implementation specifications, and certification criteria adopted in this final rule will help ensure that certified EHR technology on the market can maintain data confidentiality, share information securely, and perform a well-defined set of functions to help health care providers realize the full potential of EHRs and electronic health information exchange.

With the adoption of the initial set of standards, implementation specifications, and certification criteria completed, we are now ramping up the development of other processes that will need to be in place to enhance interoperability. Many of these processes will be components of a comprehensive standards and interoperability framework under development by ONC to expedite standards harmonization as well as their adoption and use. We anticipate that this framework will: assist in managing the standards lifecycle; enable the reuse of standards

components to expedite standards development for new business scenarios; provide a way for semantic discipline (i.e., to ensure computability and traceability); and allow for greater coordination among stakeholders. Over time, we anticipate that the standards and interoperability framework will assist the HIT Standards Committee as it considers standards and implementation specifications for adoption by HHS.

We are also continuing to coordinate within the Executive branch on complementary activities where the use of adopted standards and implementation specifications may be appropriate. In this regard, on February 19, 2010, Director Orzag and Secretary Sebelius co-signed an Office of Management and Budget (OMB) Memorandum 10-10 entitled "Federal Agency Coordination on HIT" which created an interagency HIT Task Force to facilitate implementation of the President's HIT agenda through better coordination among Federal agencies. As noted, under the aegis of this HIT Task Force, we are working with Mr. Howard Schmidt, to leverage security lessons learned from other Federal programs, supporting our colleagues at the Department of Defense and the Department of Veterans Affairs on their implementation of the Virtual Lifetime Electronic Record (VLER) project, and have continued our work with the Federal Health Architecture (FHA). ONC has also maintained a close working relationship with HHS' Office for Civil Rights (OCR) and consulted with OCR as they developed the proposed modifications to the HIPAA Privacy, Security, and Enforcement Rules required by the HITECH Act to strengthen the privacy and security protections for health information and to improve the workability and effectiveness of the HIPAA Rules. The proposed regulation provisions would, among other things, expand individuals' rights to access their information and restrict certain disclosures of protected health information to health plans; extend the applicability of certain of the Privacy and Security Rules' requirements to the

business associates of covered entities; establish new limitations on the use and disclosure of protected health information for marketing and fundraising purposes; and prohibit the sale of protected health information without patient authorization. This proposed rulemaking will strengthen the privacy and security of health information, and is an integral piece of the Administration's efforts to broaden the use of HIT in health care today.

The Temporary Certification Program Final Rule

As previously mentioned, in order to provide assurance to eligible health care providers that the EHR technology they adopt will assist their achievement of meaningful use under the Medicare and Medicaid EHR Incentive Programs, HHS issued at the end of June a final rule establishing the Temporary Certification Program for health information technology. The Temporary Certification Program final rule outlines how organizations can become ONC-Authorized Testing and Certification Bodies (ONC-ATCBs). Once authorized by the National Coordinator, ONC-ATCBs will test and certify that EHR technology is compliant with the standards, implementation specifications, and certification criteria adopted by the Secretary.

We strove to balance speed with rigor in our proposals for the establishment of the certification programs. In order to reduce market uncertainty and the potential for delay with respect to the adoption and implementation of certified EHR technology, we determined that it was necessary to implement in the very near term, a strong, but temporary certification program, while in parallel working to establish a more rigorous permanent certification program that would be able to achieve greater incorporation of international standards and best practices for third-party conformance assessment, including requirements such as accreditation and surveillance. We intend to publish a final rule for a Permanent Certification Program this fall. We expect the permanent certification program will be fully operational sometime in early 2012.

Additionally, in accordance with the HITECH Act, ONC consulted extensively with our colleagues from the National Institute of Standards and Technology (NIST) in the development of our proposals for both the temporary and permanent certification programs. We received valuable input from the experts at NIST and will continue to work with them as the certification programs mature.

In approximately four weeks since the Temporary Certification Program rule was finalized, ONC has already distributed 32 applications to organizations seeking to become ONC-ATCBs to test and certify EHR technology. Of these, 26 requested authorization to test and certify Complete EHRs, or "all-in-one" EHR technologies that meet all applicable certification criteria adopted by the Secretary, while another 6 have requested authorization to test and certify EHR Modules, specialized EHR technologies that meet at least one, but not all, of the certification criteria adopted by the Secretary. I am highly encouraged by the strong interest shown thus far, and I am optimistic that multiple organizations will be granted ONC-ATCB status, and thus authorization to test and certify Complete EHRs and/or EHR Modules under the Temporary Certification Program. Such a result should create a competitive market, would provide EHR technology developers with multiple options (relieving a concern we heard about regarding the possibility of long lines for EHR technology developers to have their products tested and certified), and could lower the costs to EHR technology developers that are associated with testing and certification.

HITECH Programs

ONC is engaged in a number of crosscutting activities related to administering the provisions of the HITECH Act. The major program investments established to date with the $2 billion appropriated to ONC under ARRA include: the Health Information Technology

Extension Program; the State Health Information Exchange Cooperative Agreement Program; the Beacon Community Cooperative Agreement Program; the HIT Workforce Program; and the Strategic Health IT Advanced Research Projects Program.

The Health Information Technology Extension Program

The Health Information Technology Extension Program includes the establishment of a national Health IT Research Center (HITRC) and a nationwide network of RECs. RECs will be dedicated to ensuring that providers have all the necessary resources to meet the challenges ahead to adopting and becoming meaningful users of certified EHR technology. They will place a special emphasis on providing technical assistance to clinicians furnishing primary-care services from an individual or small group practice. Clinicians in such practices deliver the majority of primary care services, but have the lowest rates of EHR adoption and the least access to resources to help them implement, use and maintain such systems.

The goal of the RECs is to provide outreach and support services to at least 100,000 priority primary care providers within two years. Presently, ONC has awarded grants to 60 RECs located throughout the United States. Over $700 million has been devoted to the RECs, with an additional $50 million invested in establishing the HITRC. The HITRC will be assembling and disseminating materials to support and address the needs of all prioritized providers and working with special needs patient populations.

The State Health Information Exchange Cooperative Agreement Program

The State Health Information Exchange Cooperative Agreement Program has the overall aim to advance appropriate, secure, and sustainable HIE within and across states and other jurisdictions. Over $500 million has been obligated to 56 states, eligible territories, and qualified State Designated Entities (SDE) to support health care providers, demonstrate the meaningful

use of certified EHR technology and to leverage the additional efficiencies and quality improvements gained from HIE. The state cooperative agreements are designed to be flexible enough to support states and providers at multiple levels of HIE adoption, recognizing the important investments already made at the regional and state levels.

Participating states are expected to develop and implement strategic and operational plans to ensure that there is measurable progress within states toward meeting the meaningful use measures that require the exchange of electronic health information. They are also encouraged to use their authority and resources to coordinate with Medicaid and state public health programs, convene stakeholders, and develop technical services to enable interoperability.

The Beacon Community Cooperative Agreement Program

The Beacon Community Cooperative Agreement Program provides certain communities with funding to build and strengthen their HIT infrastructure and HIE capabilities. These communities will demonstrate the vision of a future where hospitals, clinicians, and patients are meaningful users of HIT, and together the community achieves measurable improvements in health care quality, safety, efficiency, and population health. Using HIT as a tool to enable other delivery system changes, each Beacon Community is setting specific performance improvement targets for cost, quality, and population health. We anticipate that this program will demonstrate how HIT can help stakeholders develop innovative ways of delivering care leading to sustainable and measurable health and efficiency improvements. The Beacon Community Cooperative Agreement Program has obligated $220 million to 15 communities and is in the process of awarding an additional $45 million to support two more communities, technical assistance and program evaluation. The Beacon Communities are required to coordinate their activities with the RECs and State Health Information Exchange Cooperative Agreement Program.

The HIT Workforce Program

The HIT Workforce Program is a multi-pronged approach designed to support the education of HIT professionals, including curriculum development, competency examinations, and training. An increased workforce of skilled HIT specialists will be essential to supporting providers as they transition to certified HIT technologies. To date, ONC has obligated over $80 million in total funding to achieve the overall goal of training up to 45,000 new HIT workers to assist health care providers in becoming meaningful users of certified EHR technology. Training will focus on core HIT professional roles, and standardized competency examinations will be used for credentialing.

The Strategic Health IT Advanced Research Projects (SHARP) Program

To implement the provisions of the HITECH Act that focused on innovation, we have obligated approximately $60 million to support the SHARP program. The SHARP program funds research projects across four universities focused on achieving breakthrough advances to address well-documented problems that have impeded adoption. These projects are guided by a two-part ONC strategy: to implement a collaborative, interdisciplinary program of research addressing short and long-term challenges in their respective focus area; and to develop and implement a cooperative program between HIT stakeholders – researchers, industry, health care providers, and others – to transition the research findings into practice. The research projects will focus on security of health information technology; patient-centered cognitive support; healthcare application and network platform architectures; and secondary use of EHR data.

Conclusion

The HITECH Act provides for an unprecedented level of funding to improve the quality and efficiency of health care through HIT, and its historic investment will undoubtedly help

transition our current antiquated, paper-dominated health care system into a high-performing 21st century health care system. It was my privilege to testify before you today and I look forward to continuing to work together and answering any questions you might have.

Mrs. CAPPS. Thank you very much, Dr. Blumenthal.
Now Mr. Trenkle for your testimony.

STATEMENT OF ANTHONY TRENKLE

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

On January 13, 2010, we published a proposed regulation that defined meaningful use and described the eligibility and payment methodologies for the EHR incentive programs. This NPRM was developed through close cooperation between CMS and the Office of National Coordinator and also allowed for extensive stakeholder input and recommendations from several federal advisory committees, in particular the HIT policy committee. The NPRM laid out three stages of meaningful use with stage 1 covering the first 2 years of the program. We received more than 2,000 comments on the proposed rule from interested stakeholders including health care providers, associations and patients. Most of the commenters felt that the proposed set of objectives was too difficult for stage 1 and asked for some flexibility in meeting them. The agency carefully reviewed and considered all submitted comments and took them into account in making policy decisions for the final rule. Our goal was to be as inclusive and flexible as possible within the bounds of the statute. We continued to work closely with ONC and received additional recommendations from the HIT policy committee. It is important that this program provides payment incentives for both Medicaid and Medicare. The programs have different statutory requirements but we tried to harmonize the meaningful-use requirements as closely as possible for stage 1. Both the CMS rule and the ONC certification standard rule, which sets out the functionality requirements for EHR, were displayed the Federal Register on July 13, 2010, and will be published in the Federal Register tomorrow, July 28, 2010.

I will now discuss some of the key areas of the final rule. Eligible professionals, the major change in that was to expand the definition of "eligibility" to hospital-based physicians who work primarily in outpatient departments. This is made possible by a change to the original statutory language made in the Continuing Education Extension Act of 2010. Most Medicare Advantage-affiliated eligible professionals will also quality for this incentive if they are able to show meaningful use, and on the Medicaid side we provide additional flexibility for determining patient volume in order to quality more EPs.

Eligible hospitals—we have received, as was noted by a number of the committee members, much comment and request that CMS recognize each campus of a multi-campus hospital for the incentive payments. We understand that this issue of importance to Members of Congress, the hospitals and the public. However, from the

agency's perspective, we believe it is important to treat hospitals consistently, and the decision to deviate from longstanding policy in this particular instance without clear statutory direction to do so would have made CMS vulnerable to legal challenges asserting our policies are being implemented in an arbitrary manner. We intend to remain consistent with other payment policies and make incentive payments based upon how hospitals have organized themselves under provider numbers. There is a more detailed discussion of this issue in my written testimony and I am happy to respond to questions on this. We will continue to work with all interested stakeholders in future rulemaking related to the implementation.

The other major hospital issue was with the Medicaid program, and in response to public comments on the proposed rule, we added critical-access hospitals to the definition of a Medicaid acute hospital in order to allow CAHs to quality for both programs. The major changes we made in the rule were with the meaningful-use definitions. As we mentioned in the NPRM, we received a number of comments that asked for more flexibility, and we decided to make some changes based on these comments that I will address in the next few moments.

Some of the major changes were modifying the all-or-nothing approach to objectives that must be met for meaningful use and reducing this requirement to a required set or a core and a menu set or optional set. Eligible hospitals and professionals have the flexibility to defer up to five of the menu set objectives. Where appropriate thresholds to meet meaningful-use requirements were reduced in the final rule in response to comments. We also removed the administrative transaction requirements in the final rule in response to comments these transactions are often done through practice management software as opposed to EHRs. We also modified the States' ability to impose more-robust requirements that would have made it more difficult for Medicaid providers to achieve elevated targets. We believe it is important for States to have some flexibility so we preserved the flexibility. However, in response to the concerns raised, it was limited to four public health measures. We also added additional objectives for patient-specific education resources and advanced directives for hospitals were added in response to numerous requests in the comments and the HIT policy committee recommendations.

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

Finally, I want to mention that Congress recognized the critical importance of reporting quality measures through EHRs in the HITECH legislation. We support this requirement but recognize that the infrastructure to support the reporting of quality measures

through EHRs is not yet available. In response to comments, CMS limited CQMs to only those which have electronic specifications. Eligible providers will now be required to report on three core measures from a set of 41 measures. Hospitals will be required to report on 15 measures as applicable to their population.

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

Thank you very much for allowing me to testify.

[The prepared statement of Mr. Trenkle follows:]

STATEMENT OF

TONY TRENKLE

DIRECTOR,
OFFICE OF E-HEALTH STANDARDS AND SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

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

BEFORE THE

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

JULY 27, 2010

CMS TESTIMONY

Electronic Health Records (EHR) Medicare/Medicaid Incentive Payment Program
U.S. House Committee on Energy and Commerce
Subcommittee on Health
Hearing on Health Information Technology
July 27, 2010

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

Background

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

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

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

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

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

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

Key Components of the CMS Regulation

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

Eligible Professionals

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

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

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

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

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

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

Eligible Hospitals

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

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

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

(1) An initial amount which is the sum of a $2 million base amount and the product of a per discharge amount and the number of discharges;

(2) The proportion of fee-for-service and managed care inpatient bed-days (attributable to either Medicaid or Medicare, depending on which EHR incentive program) for the eligible hospital to the product of total inpatient days and by the hospital's proportion of total charges that are not attributed to charity care; and

(3) A transition factor which phases down the incentive payments over the four year period.

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

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

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

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

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

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

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

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

Critical Access Hospitals

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

Meaningful Use

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

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

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

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

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

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

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

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

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

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

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

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

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

Future Stages of Meaningful Use

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

Clinical Quality Measures

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

States' Medicaid EHR Incentive Programs

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

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

Conclusion

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

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

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

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

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

Mrs. CAPPS. And you are reaching out to these communities?

Dr. BLUMENTHAL. Yes, we are.

Mrs. CAPPS. OK. So that they know about what services they can be eligible for?

Dr. BLUMENTHAL. We certainly are making every effort to make those services known.

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

Dr. BLUMENTHAL. Well, exchange is absolutely essential to good health-care management. Knowing what your patients' experiences have been in other locations is a great benefit, potential benefit of health information technology. At the same time, we need to make it possible for exchange to occur. It is not something that is under

the control of individual providers. Exchange is in many ways a team sport. You need to have someone out there to get your pass when you throw the pass and you need to be able to take the pass when it comes back to you. So the health information exchange cooperative agreement programs that provide funds to the States are meant to empower the States and encourage the States to lead in the development of health information exchange capabilities within state jurisdictions and across state jurisdictions. Similarly, the Office of the National Coordinator has undertaken an aggressive program for the development of new standards and technologies that can provide a tool kit for exchange that the States can use and that local service providers can use.

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

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

Mrs. CAPPS. So there is a network that is building within the State and then will that filter——

Dr. BLUMENTHAL. Absolutely. That network has to be created or else exchange will not continue.

Mrs. CAPPS. Thank you very much.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Madam Chair.

First, I want to segue into and follow on the line of questioning that Mrs. Capps talked about. Also, there is a provision on the absence of physical therapy as part of being not eligible to receive and I just want to throw that out there. I think your answer would be very similar in the response. But I think it is worth noting that there are some gaps there and there will be a debate on who is eligible and who is not eligible.

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

Dr. BLUMENTHAL. Well, Congressman, the law specifies what will happen for failure to meet meaningful use.

Mr. SHIMKUS. And since you are implementing that law, what would that be?

Dr. BLUMENTHAL. Well, as of 2015, eligible providers that have not implemented, not become meaningful users would be potentially penalized in their Medicare and Medicaid——

Mr. SHIMKUS. When? When will that start? When will the penalties start?

Dr. BLUMENTHAL. Twenty fifteen.

Mr. TRENKLE. Yes, 2015 is specified in the legislation.

Mr. SHIMKUS. We don't have any idea based upon where people are in a survey of projection of how many providers may be penalized?

Dr. BLUMENTHAL. I think it would be premature to speculate about that.

Mr. TRENKLE. We put some estimates in the impact analysis as part of the regulation, but——

Mr. SHIMKUS. And what would those analyses show?

Mr. TRENKLE. We had both a high- and a low-end projection for that.

Mr. SHIMKUS. I will give you a chance to look for that.

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

Mr. SHIMKUS. You know, and I think from colleagues on both sides of the aisle, especially those of us who represent rural communities, I think, you know, our one of many concerns would be major institutions have the capital or the foundations to move in the aggressively upfront cost. Poor, rural hospitals do not, and our concern is the timeline and our concern would be then when they are servicing in poor areas that they will then have a penalty when they are still trying to comply. So that is part of the question.

Mr. TRENKLE. Excuse me just a second, but the numbers I gave you were for the professionals, not for the hospitals.

Mr. SHIMKUS. Well, it is true for them too.

Mr. TRENKLE. Right. I understand.

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

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

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

Mr. TRENKLE. For the purpose of the impact analysis, we did both a high- and a low-end scenario. As I mentioned a few moments ago, those are based on studies and actuarial projections. We also changed some of the numbers based on input we received from

a number of organizations including the American Hospital Association, which allowed us to actually we had to lower the lower end because some of the cost projections and projections of getting up to speed had to be lowered because of the longer implementation lead time they projected.

Mr. SHIMKUS. Thank you, Madam Chair.

Mrs. CAPPS. Mr. Waxman, the chairman of the full committee, is recognized for his questions.

The CHAIRMAN. Thank you, Madam Chair.

The gathering of health IT should not be a goal in itself. It is a worthy goal, but that is not the only reason we want it. The lack of timely clinical information is a contributor to our Nation's well-documented problems with uncoordinated care. Health IT is a tool that can help deal with that problem right at the time of the patient's visit. The health reform legislation contains numerous policies to improve the delivery system such as establishing accountable care organizations, reducing hospital readmissions and moving towards greater bundling of services.

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

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

Mr. TRENKLE. I would follow up on what Dr. Blumenthal with the fact that we are actually building infrastructure over the next several years that will support much of the health reform from the electronic specifications for the quality measures to the health information exchanges and the other work we are doing will allow us to have the infrastructure, that will allow the flow of data and support many of the objectives of health reform, so we feel this is a critical first step in moving towards some of the goals set out in the legislation.

The CHAIRMAN. Is it fair to say that without health IT we wouldn't be able to have the reforms be as successful as we hope them to be?

Dr. BLUMENTHAL. Well, I would certainly agree with that, Mr. Chair.

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

Dr. BLUMENTHAL. That is an excellent question. We are working with our sister agencies to try to define how records can privately and securely capture and make available information that is relevant to the missions of other agencies like the Food and Drug Administration or the National Institutes of Health or the Agency for Health Research and Quality or the Centers for Disease Control and Prevention, how we can, for example, in real time learn about the occurrence of influenza-like illness so that we can keep track of influenza epidemics and know where vaccine needs to be administered or keep track of foodborne illness outbreaks though real-time availability of information on related types of illness. So there is an enormous public health benefit and there is enormous value with patient consent and agreement recruiting patients into clinical trials for relevant new experiments whether it is in cancer or heart disease or diabetes, patients who want to be part of these experiments but who might otherwise be located without the benefit of the information that is available in electronic form.

Mr. TRENKLE. Let me also mention that under the meaningful-use objectives, one of the major goal areas was to improve population in public health and we included a number of objectives that provide for the capability to exchange public health data, and as I mentioned in my testimony earlier, we are also allowing States to have the flexibility to make some of these objectives core measures and core objectives for the purposes of meeting the meaningful-use criteria for the incentive program.

The CHAIRMAN. Thank you. I yield back my time.

Mrs. CAPPS. Thank you, Mr. Chairman.

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

Mr. GINGREY. Madam Chair, thank you very much.

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

Dr. BLUMENTHAL. Congressman, our concern and the concern of the policy committee that you cited was to take maximum advantage of health information technology and electronic health records to improve the safety of concern, and what actually the committee focused on in addition to the FDA was other alternatives for collecting information about the implementation of electronic health records to make sure that those implementations are as safe as they could possibly be. So we also discussed using patient safety organizations and using our new certification to collect post-market, post surveillance, post-certification surveillance information. So I think that the mandate to us, the recommendation to us, not a mandate, was to develop and look at all the ways we could collect information to make sure that our work was doing everything it possibly could to enhance patient safety.

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

Mr. GINGREY. Mr. Trenkle, do you have any further comments on that?

Mr. TRENKLE. No, I agree with what Dr. Blumenthal said.

Mr. GINGREY. I thank you. I hope that I understood correctly your response, Dr. Blumenthal, that you really don't think that the FDA should treat electronic medical records as a medical device.

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

Mr. GINGREY. Thanks. I have got about 2 minutes left.

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

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

Mr. GINGREY. Well, I don't want to interrupt you, but I definitely want to ask Mr. Trenkle a question before my time runs out. I have 10 seconds.

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

Mr. TRENKLE. I just want to add one thing to the previous question on the meaningful use stage 2. We have, in addition to what David mentioned, we have also signaled in the preamble for this particular rule that we were going to move the menu items to the

core objectives for stage 2 and also signaled our intent to add administrative transactions in stage 2 as well as increasing the percentage measurement for computerized physician order entries. So we have given some signals.

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

Mr. GINGREY. But they would each be eligible if they did for the bonus payment?

Mr. TRENKLE. That's correct.

Mr. GINGREY. Mr. Chairman, thank you. I thought that was very important. I am glad you let him answer.

Mr. PALLONE. Thank you.

Our chairman emeritus, Mr. Dingell, is recognized.

Mr. DINGELL. Thank you, Mr. Chairman.

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

Dr. BLUMENTHAL. I don't think that is going to be a problem, Mr. Dingell.

Mr. DINGELL. It does have the potential, though, does it not?

Dr. BLUMENTHAL. If certified technology were not available, yes, it would have that.

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

Dr. BLUMENTHAL. I don't think that is going to happen, but yes, that is correct.

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

Dr. BLUMENTHAL. I agree with that.

Mr. DINGELL. And I don't want you to be defensive about this. I just want you to understand, I have the apprehension if we don't make these things flow, there is going to be trouble.

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

Dr. BLUMENTHAL. That is correct.

Mr. DINGELL. Now, what has the Administration done to remove the potential uncertainty surrounding certification to ensure that we have as much as early participation for providers as possible?

Dr. BLUMENTHAL. Well, we have already published in mid-June a final rule creating a temporary certification process which will be in existence until the final permanent process is available. That

process can certify records, will certify records, will certify them by the fall, so that we believe there will be ample time for eligible providers to have not only installed a record but have some time to look them over, think about what they want to install, and then some time to install them, and still qualify for the full payments available under the incentive plan.

Mr. TRENKLE. Congressman Dingell, can I make a comment also? One of the things we took into account when establishing the criteria for meaningful use is to have a 90-day reporting period in year one in recognition of the fact it will take some time to set up the certification program and also to allow the providers and hospitals additional time to sign up for the program and demonstrate meaningful use.

Mr. DINGELL. Thank you. I think you are both telling me then that the temporary program is necessary but that it is not going to be sufficient over the long haul. Is that correct?

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

Mr. DINGELL. Now, will the technology certified through the temporary program be subjected to additional certification under the permanent program?

Dr. BLUMENTHAL. It will continue to be certified for stage 1 until additional criteria come into play.

Mr. DINGELL. Now, Dr. Blumenthal, I note that HITECH has made substantial program investments including funding for support of the Beacon Community Cooperative Agreement program. The first round of awards were announced, and I understand that there were strong applications from Michigan, but I also understand that none of the Michigan applications were selected. Am I correct that you plan to announce two additional awards?

Dr. BLUMENTHAL. You are correct, sir.

Mr. DINGELL. And am I to assume that Michigan will be most sympathetically considered?

Dr. BLUMENTHAL. We will give it every sympathetic consideration, sir.

Mr. DINGELL. I will be looking forward to that. What will be the timeline for this announcement?

Dr. BLUMENTHAL. Middle of August, I believe.

Mr. DINGELL. Beg your pardon?

Dr. BLUMENTHAL. Mid-August, I believe.

Mr. DINGELL. Now, I would like to get your assessment of the current EHR marketplace. HITECH included a provision that would require your office to make certified EHR technology available if the marketplace fails to do so. Is that correct?

Dr. BLUMENTHAL. That is correct.

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

Dr. BLUMENTHAL. I do believe so.

Mr. DINGELL. Mr. Chairman, I note my time has expired and I thank you for your courtesy.

Mr. PALLONE. The gentleman from Texas, Mr. Burgess.

Mr. BURGESS. I thank the chairman.

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

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

Mr. BURGESS. Another thing that I have encountered, I don't know if it has come up——

Dr. BLUMENTHAL. Congressman, if I could just make one amendment to that?

Mr. BURGESS. Yes.

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

Mr. BURGESS. How many of those working groups do you have?

Dr. BLUMENTHAL. We have several, so it would be quite possible to include them.

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

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

Dr. BLUMENTHAL. Well, in the period between 2011 and 2015, they fail to accumulate the incentive payments that are available. In 2015 and beyond, they are subject to the penalties that were placed in the law with respect to Medicare reimbursement.

Mr. BURGESS. So if a practice elects to do nothing, it is not that they will just ultimately be left alone, they ultimately would be penalized by the provisions of HITECH and ARRA?

Mr. TRENKLE. Yes, if they are under the Medicare program if they qualify.

Mr. BURGESS. And what——

Mr. TRENKLE. And that was legislatively mandated. That was part of——

Mr. BURGESS. But what are the penalties that they are looking at?

Dr. BLUMENTHAL. I will let Mr. Trenkle answer that.

Mr. TRENKLE. The penalties are as they were put into the legislation. It is 1 percent in 2015 and then it goes upward beyond that, but we implement them as they were put into the legislation.

Mr. BURGESS. And just for the record, I argued strenuously against that type of punitive approach to this because I don't know if we have allowed ourselves enough time to ramp this up. Dr. Blumenthal, you have worked a Herculean effort this past year to get where you are right now. Imagine putting that effort on top of a small physician practice working 16 hours a day just to take care of their patients and pay their bills and keep their doors open with all of the other stipulations we have put up them. This one does seem onerous. For either of you, how many providers are going to be penalized? Do you have some notion as to how extensive this is going to be?

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

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

Mr. BURGESS. Maybe you could get back to me with that in writing because I am going to run out of time and I would be interested in your response to that.

Mr. TRENKLE. OK.

Mr. BURGESS. But I guess one of the other follow-up questions I have is, obviously there are going to be people who have these systems for sale. Now, the people who have the systems for sale, the vendors, are they under any sort of punitive aspects under this law or do they just simply present their wares for sale and that is that?

Mr. TRENKLE. No, they are not under any penalties. The only issue with the payment adjustments was what was in the legislation.

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

Dr. BLUMENTHAL. Well, the provisions of the law are the provisions of the law, Mr. Congressman, as you well know, so we have limited—what we are doing is working very hard to make sure that every well-intended provider who wants to be a meaningful user has the opportunity to become a meaningful user and that—but they won't fail through any lack of effort on our part. So that is

I think our commitment at the Office of the National Coordinator and from the federal government.

Mr. BURGESS. But with all due respect——

Mr. PALLONE. The gentleman's time is a minute and a half over.

Mr. BURGESS. I will follow up with this in writing because this is an important point, and we have already seen how your rulemaking has progressed since the beginning of the year, and it is going to affect practices all over the country.

Mr. PALLONE. Thank you. Let me mention that you will get additional questions from us in writing, and any member is entitled to do that.

The gentlewoman from the Virgin Islands, Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you both, Dr. Blumenthal and Mr. Trenkle.

My first question is to you, Mr. Trenkle. The territories are not included in the EHR program under Medicare and Medicaid. It is just the 50 States and the District of Columbia. Is the reason because we don't use a prospective payment program? I don't see why that should make a difference but you can explain if it does. And Medicaid is different in the territories, and while I don't agree with that either, Medicare is not. And in the territories, Medicaid can only be used in public hospitals and public clinics. So why are we excluded?

Mr. TRENKLE. In determining eligible professionals and hospitals, we followed what was in the statute.

Mrs. CHRISTENSEN. OK. So we did it?

Mr. TRENKLE. Right, so you did it.

Mrs. CHRISTENSEN. We will try to see what we can do about that because it really shouldn't—in the territories, Medicare beneficiaries and Medicaid beneficiaries should benefit from the same benefits of HIT as everyone else. Don't you agree?

Mr. TRENKLE. Yes, I agree. As I said, we followed what was in the statute, so——

Mrs. CHRISTENSEN. Thank you.

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

Dr. BLUMENTHAL. Well, I would like to get back to you with specific numbers. I can tell you that my memory is that the communities' populations are representative of the underserved populations in the country as a whole. The beacon community program was awarded, vendors were chosen through an objective review competitive process. As a matter of fact, it took place in the record-breaking snowstorm in February, and we funded those programs in the order in which they were picked by the external reviewers, just as an NIH grant would be awarded. The criteria took into account of course the quality of the application. It did take into account diversity. Seven of the 15 are rural communities. And it took into account the commitment of the communities, the quality of the health

IT infrastructure, the governance arrangements and the believability, the credibility of their goals which were very precisely laid out in the applications.

Mrs. CHRISTENSEN. Did you identify or have to respond to any unique challenges in the implementation process or through the comment process from poor, rural or communities of color?

Dr. BLUMENTHAL. We certain tried to. There is a beacon community in the Mississippi delta. There is one in the Piedmont area of North Carolina. There is one in Tulsa, Oklahoma. So they really go from Hawaii to upper New York and I think are quite representative of the country as a whole.

Mrs. CHRISTENSEN. And I guess to both of you, and you may have answered this already but I didn't see it in reading your testimony specifically. How have the providers been incorporated into the setting of the standards, not just in the comment period but as you were developing the standards? Were doctors, hospitals, other providers included?

Dr. BLUMENTHAL. We have two advisory committees that you all provided us under the statute, the policy committee and standards committee. They meet in public. Their work groups meet in public. We have had over 180 public meetings of those groups. We have had testimony from a wide range of advisors.

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

Dr. BLUMENTHAL. Well, progress notes are not part of the requirement for meaningful use in stage 1, so yes, there would be an opportunity to dictate into the record in stage 1.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Next is the gentleman from Ohio, Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman.

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

Mr. TRENKLE. As I mentioned in my written and in my oral testimony that we base this on existing policy and the provider number is based on how the hospitals choose to organize themselves for payments under other Medicare programs, so what we did here without clear statute intent was to be consistent with the payment policies that we have adopted for other programs, many of which, as I said, were due to hospitals themselves wanting to be organized in this manner to be paid in a certain way.

Mr. SPACE. So absent clear statutory intent, at this point you don't envision reconsideration of that rule?

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

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

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

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

Mr. SPACE. Thank you, Dr. Blumenthal and Mr. Trenkle.

I yield back my time, my one second.

Mr. PALLONE. I thank the gentleman and recognize the gentleman from Connecticut, Mr. Murphy.

Mr. MURPHY OF CONNECTICUT. Thank you very much, Mr. Chairman. Thank you both for your all your work and for being here today.

I wanted to build on a question that Chairman Waxman raised, and let me first pose it to you, Dr. Blumenthal. I think one of the most exciting pieces of the health care reform bill is the path forward we have set on the change in delivery system and the change

in which we pay for medicine to really move from a system in which we today value volume to a day in which we can place the appropriate value on outcomes and quality. I am obviously very happy to hear your emphasis on the connection between health care IT and the day in which that can happen. I think your response to him was in regard to accountable care organizations, which I think will be transformative.

I wanted to ask you about some other potential payment changes and new models of delivery. One of the pilot programs that I and others worked very hard on was looking at new ways to bundle payments in particular with respect to post-acute care, and in that setting, you are dealing with complex patients that are coming in and out of hospital and physician settings, often having some of their most expensive care in, for instance, skilled nursing facilities. I know we can't cover everybody with the payments in this law but I wanted to get your thoughts on how we continue to broaden out the number of providers that are eligible for these payments, or in the absence of doing that, how we find a way to get comprehensive health care information technology to places like skilled nursing centers so that we can really implement these payment delivery system changes that we know have the potential to do some great things.

Dr. BLUMENTHAL. Well, in my role as a provider, as a practitioner, a primary-care practitioner, I am extremely sympathetic to the need to bring long-term care, home care, rehab in coordination and get the information from those sites into the acute care part of the system. As you pointed out, the law as currently structured does not make incentives available to those provider settings, and that is a limitation. It doesn't prevent, though, those institutions from finding electronic heard record technology themselves, especially if bundled payment arrangements were to make available some savings that they could get access to and if having that technology enabled those savings as I am certain it would.

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

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

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

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

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

Dr. BLUMENTHAL. The requirements for certification are new because the meaningful-use requirements are new, and we know that frequently technology that is in place, though it may be beneficial, doesn't meet the standards or the certification requirements that meaningful use has created. So we can't assume that technology in place right now is capable of supporting meaningful and therefore we can't assume that it is certified. So yes, if you have technology right now that hasn't been certified under the new certification process, you will have to get it certified. It may be quite easy to do that. It may be that you have technology that is very capable. But we can't assume that, and we don't want to create the impression for providers that something they are using now will be capable of meaningful when it is not.

Mr. MURPHY OF CONNECTICUT. Nothing preventing an existing system from being stamped as certified as long as it meets that requirement?

Dr. BLUMENTHAL. Absolutely not.

Mr. MURPHY OF CONNECTICUT. Thank you. Again, thank you for all your work. This is incredibly important. I appreciate your being here.

Mr. PALLONE. Thank you, Mr. Murphy. I am going to recognize myself since I wasn't here earlier.

I assume, and I missed the beginning, that there was some discussion about meaningful but it is the most or one of the most controversial aspects of this round of rulemaking, and demonstrating meaningful use is the key to attaining eligibility for incentives for Medicare and Medicaid so there is a lot of interest from provider communities about how those rules are structured. So I wanted to ask each of you, first, Mr. Trenkle, you have been criticized for setting the bar too high for providers to demonstrate meaningful use. Others have said the agency isn't demanding enough from providers. I actually haven't heard that one. Please, if you would explain to the committee how you define the balance between high standards and reasonable expectations and how the final rule reflects that balance. – – –

Mr. TRENKLE. Yes, I would be happy to do that. I think it is important to point out that the final regulation reflects a 17-month process. The Recovery Act was passed in February of 2009. The final rule came out in July of 2010. And during that time we convened several committees that as Dr. Blumenthal mentioned received input from a number of stakeholders. We had a public com-

ment period of 60 days. We came out with a notice of proposed rulemaking. We heard back from the community that a lot of the objectives were too high so we adjusted in response to the comments. So I think a combination of all these efforts have led us to what we believe is a balance between a strategic framework for promoting future adoption and meaningful use and recognizing the realities of the infrastructure and the adoption rates today.

Mr. PALLONE. I mean, I guess the concern that I hear is that a lot of providers simply won't meet the bar and then our efforts are in vain, but at this point you don't feel that is the case?

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

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

Dr. BLUMENTHAL. I believe they will. I believe there are tens and even hundreds of thousands of physicians who are already effectively using electronic health records and are close to meeting meaningful-use criteria. By the way, that is true of many small hospitals as well, critical-access hospitals. I have met with them and seen them with my own eyes. So I think it is quite possible to do this, and the question will be whether the physicians and hospitals feel that it is possible and will devote themselves and make the effort. We have to make sure that the taxpayer was rewarded with getting real value from these records for the tens of billions that were in the legislation, but at the same time we have to make sure that it was achievable, and that is a balance that we have been trying to find constantly over this 17-month period. We will closely at what the experience is, try to learn from that experience and see whether we have set the bar at the right level. So we have done our due diligence. We have made our best analyses and we are moving forward from there.

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

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

Mr. PALLONE. But that is not something you are doing in this first round, in other words?

Mr. TRENKLE. No, because the adjustments aren't scheduled to come in until 2015 so we will be addressing that in future rulemaking.

Mr. PALLONE. All right. I know I have got a couple minutes here. I just wanted to ask, you know, I always get the questions, Dr.

Blumenthal, about the small practices. The majority of physician practices continue to be small practices of one or a few physicians and of course, you know, given the economics today, a lot of them are struggling, and it is an investment obviously to move towards health IT and they say it is going to decrease productivity when it is initially implemented, a lot of things of that nature. What would you say about that? I mean, the HITECH Act provides $2 billion to your office but there is also the regional extension centers and beacon community programs. Is this going to be some way to help these single practitioners, or how do you envision that?

Dr. BLUMENTHAL. Well, the small practice if the target of the Regional Extension Center program. That is where we are focusing our effort because we realize that those are the practitioners who are going to have the hardest time and are going to be the least attractive and have the fewest resources to attract a commercial vendor, a commercial consulting company or a so-called integrator to help them. So we are intending to enroll 100,000 small practices through the Regional Extension Center program in programs to assist them becoming meaningful users, and I think that is going to be a big opportunity for small practices, and over time I think we will learn how to do that better and better and we will continue to provide that. That is over the first couple of years. Later on I think we will be able to do more as time goes on. So they are very much aware of this group and the practice is changing and younger physicians are much more adept at adopting these technologies than physicians my age, and so I think over time this problem is going to largely take care of itself.

Mr. PALLONE. All right. Thank you.

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

Mr. GONZALEZ. Thank you very much, Mr. Chairman. I apologize. I have been absent for much of the hearing, but I do thank the witnesses.

I have a couple of questions. One is going to be more parochial. I will start with the more general one, and that is going to be—and first of all, the sources of the questions come from the medical community, hospitals and such in my area because my staff is very sensitive to getting their input, and they say why don't you ask these particular questions, and they are much better questions than I would come up with on my own, so I want to make sure that I get some of the, I guess the verbiage here, the quality improvement organizations and the proposed rules, and back home they are saying because of preexisting relationships with these quality improvement organizations with the regional extension centers, what do you see prospectively as those particular right now it may be prime or subcontractors with individuals in San Antonio—I am from San Antonio—as we go forward? Will you have some of these same individuals, organizations playing a role? It seems like it would be a good idea just because of preexisting relationships and of course the expertise that they would bring to the table.

Dr. BLUMENTHAL. Our regional extension centers, which is what you are referring to, I think, here were chosen on a competitive basis. We had many more applications through the regional extension centers than we were able to fund. I think about a third, if

I am not mistaken, of our regional extension centers are quality improvement organizations so that that coincidence, that overlap already exists. Where are there are not quality improvement organizations, we are instructing the regional extension centers to work with quality improvement organizations and with all the other pertinent organizations in their community.

Mr. GONZALEZ. The other question, and I don't know how unique it is to San Antonio but obviously we have a very large military presence. At the present time we have two major military hospitals. One actually just closed recently, Wilford Hall, but BAMC is being plussed up, Wilford Hall will have a state-of-the-art ambulatory center, and we have a major VA hospital. The issue that comes up is of course can they still—will they be able to communicate, the interoperability issue that comes up, the different guidelines and requirements that maybe a military hospital or a VA may be subjected to as opposed to the other hospitals in San Antonio because there is quite a bit of overlap, believe it or not, as far as patient care. Your thoughts on that?

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

Mr. GONZALEZ. Well, thank you very much, and I yield back, Mr. Chairman.

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

Mr. SHIMKUS. Mr. Chairman, will you yield?

Mr. PALLONE. Sure.

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

Dr. BLUMENTHAL. Absolutely.

Mr. PALLONE. I agree with Mr. Shimkus. Thank you very much.

Dr. BLUMENTHAL. Thank you.

Mr. TRENKLE. Thank you.

Mr. PALLONE. And I will ask the second panel to come forward. Now, we are expecting votes on the floor fairly quickly so I doubt we will get through all seven people that are on the panel but we

are going to try to start and get as far as we can because there are seven of you, I believe.

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

Mr. STARNES. Illinois.

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

We ask each of you to limit your testimony to 5 minutes. You can certainly add additional testimony if you like and then you will get more written questions from us later, and I will start with Dr. Vozos.

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

STATEMENT OF FRANK J. VOZOS

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

I am pleased to appear before you today to highlight how the HITECH Act will support the transformation of Monmouth Medical Center by helping us successfully fulfill our goals related to the ac-

quisition and implementation of health information technology and to applaud the federal government for establishing a program that will provide incentive payments through Medicaid and Medicare to doctors and hospitals who demonstrate meaningful use of the certified EHR system.

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

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

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

As an example, in our emergency department we have invested significant resources to install many sophisticated information technology components including directing the interface between the emergency room clinical information system and hospital charts using the EDIMS computer framework. All records and tests are available of the care of the patient and it links to our medical center health information record. Repeating testing unnecessarily has declined and patient safety combined with more timely care has been the core outcome of this initiative.

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

One aspect of the new system we are very focused on is computerized physician order entry. We are dedicating significant time and effort to changing behavior of physicians to enter orders into the computer instead of handwriting them. In a teaching hospital, it becomes important to leverage that technology infrastructure such as CPOE as a teaching modality as well as a recordkeeping modality as the large resident staff interacts most frequently with the patients and completes written orders.

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

Further meaningful-use requirements with a compliance goal of 2011 at Monmouth include provisions for a physician to take advantage of EHR in their own private practice. Private physician offices and their style of practice are being taken into account as vendors are linked with these clinical partners to create the EMR interface with Monmouth. By 2011, there will be active physician connectivity with the hospital. Part of this deliberate strategy includes the costs associated with linking physicians and the medical center through EMR. What can be subsidized and what is funded by the medical center or physicians are important factors as we work through this connectivity goal. The ability to eliminate potential errors and medical errors including handwriting and timeliness of order gives clear quality markers for both private physician practice and care provided at Monmouth Medical Center.

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

Mr. PALLONE. Frank, I am going to have to ask you to summarize the rest.

Dr. VOZOS. OK. I am done. I just want to let you know that for the patients in this pilot study, we have seen a 70 percent conversion rate from people that have been using the emergency room as

their medical home now to the federally qualified health center as their primary care.

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

[The prepared statement of Dr. Vozos follows:]

Monmouth Medical Center
United States House of Representatives
Committee on Energy and Commerce

Presentation on HITECH Act and its Impact on Monmouth Medical Center

July 27, 2010

Good afternoon, Mr. Chairman, Ranking Member, and distinguished members of the committee. Thank you for inviting me to testify today. I am Dr. Frank Vozos, Executive Director of Monmouth Medical Center, located in Long Branch, New Jersey. Monmouth Medical Center is a member of the Saint Barnabas Health Care System, the largest not-for-profit integrated health care delivery system in New Jersey and one of the largest in the nation. I am also here on behalf of the New Jersey Hospital Association a non-profit association that represents healthcare providers in the Garden State on state and federal matters.

I am pleased to appear before you today to highlight how the HITECH Act will support the transformation of Monmouth Medical Center by helping us successfully fulfill our goals related to the acquisition and implementation of health information technology, and to applaud the Federal Government for establishing a program that will provide incentive payments through Medicare and Medicaid to doctors and hospitals who demonstrate "meaningful use" of a certified EHR system. I am convinced that this will promote improved efficiency and quality of care.

By way of background, Monmouth Medical Center is a 527-bed community teaching hospital that provides a full spectrum of services from neonatology to geriatric care. With more than 800 medical and dental staff members, the

medical center admits more than 22,000 adult and pediatric inpatients as well as cares for over 120,000 outpatients annually. Monmouth is one of the largest and oldest teaching hospitals in New Jersey and is the largest academic affiliate of Drexel University College of Medicine, a relationship that has spanned four decades. Monmouth is recognized by Press Ganey as a Distinguished Academic Medical Center among the nation's nine leading teaching hospitals, and is also accredited by the AAMC, Council on Teaching Hospitals as well as all other major accrediting organizations.

We are further distinguished among the landscape of health care providers in New Jersey by our relationship with the Long Branch Federally Qualified Health Center (FQHC), which opened in April, 2004, and grew directly out of Monmouth Medical Center's longtime model of providing primary care to the community through charity care clinics. It is important to note that Monmouth is the leading health care provider in the City of Long Branch, a multi-ethnic enclave of residents who are disproportionately poor, young, uninsured and members of minority groups. More than 35% of the city's population lives at or below 200% of the Federal Poverty Level. There are four census tracts within the city that have been federally designated as Low Income Medically Underserved Populations. Over a third of this population is under the age of 18. More than 34% of the city's population is Hispanic and nearly 19% is African American. Spanish is spoken at home by 19% of the city's population over the age of 5 years. Although there are 40 primary health care providers located in the area, most do not accept Medicaid or offer charity care. As a result, the medically indigent population in Long Branch and the surrounding communities use low income clinics provided through a federally qualified health center and the Emergency Department at Monmouth as their only source of health care.

Likewise, the revitalization of 150 acres of the Long Branch oceanfront has added more than 1,300 high end residential properties and 600,000 square feet of commercial space in the near vicinity of the medical center. As an attractive

and highly desirable retirement destination, the Long Branch oceanfront is being populated by "empty nesters" that as they grow in both numbers and age, are placing an increased demand on both emergency and other health services.

While Monmouth was moving fairly well down the path to HIT adoption before the passage of the HITECH Act – we actually installed our first electronic clinical information system in 1988 - the new law has certainly strengthened our ability to effectively transition to more comprehensive adoption, and we have pursued this goal enthusiastically, embarking on a facility wide effort to upgrade our health information technology capabilities on multiple fronts. As an example, in our Emergency Department we have invested significant resources to install many sophisticated information technology components, including the direct electronic interface between Emergency Room clinical information system and hospital charts using the EDIMS computer framework All records and tests are available in the care of the patient and it links to our Monmouth Medical Center health information record. Repeating testing unnecessarily has declined and patient safety combined with more timely care has been a core outcome of this important initiative.

Monmouth Medical Center's clinical information system suite of products, Cerner Millennium, is currently CCHIT (Certification Commission for Health Care Information Technology) certified. These products adhere to the requirements dealing with functionality, security and interoperability. MMC, through this investment in clinical information system architecture, is certified to the standards that are required by the Office of the National Coordinator under the terms of the American Recovery and Reinvestment Act which have electronic health information exchange requirements. On a regional level, MMC is a leader in developing protocols and infrastructure to share clinical data with four medical centers (Monmouth & Ocean County Health Information Exchange) throughout Monmouth and Ocean counties, regardless of our competitive marketplace. This is a real demonstration of our commitment to quality patient care.

Monmouth Medical Center's clinical information platform provides the ability to connect data from devices, either local or remote workstations, with the electronic medical record and the provider. This provides a strong foundation upon which telemedicine solutions and better patient care can be delivered. This interconnectivity within MMC allows data to be sent and received as well as safely stored based on CCHIT HIE specifications. Safe storage means our patient data is remotely stored so if there is a catastrophic occurrence to our computer system or facility, this critical patient data is kept whole. This software has been certified that it follows all recommended and required guidelines to protect patient health information. All individuals accessing the data are electronically tracked and recorded. Usage reports will be produced and sent to our Medical Records department to verify the appropriate usage of this information.

One aspect of the new system we are very focused on is Computerized Physician Order Entry (CPOE). Monmouth is dedicating significant time and effort to changing the behavior of physicians to enter orders into a computer instead of handwriting them. In a teaching hospital, it becomes important to leverage technology infrastructure such as CPOE as a teaching modality as well as record keeping as the large resident staff interacts most frequently with patients and complete the written orders.

Monmouth Medical Center's choice in new clinical information system architecture and electronic health record system is currently being used by public health facilities throughout the world. This undertaking and investment in clinical information systems has been carefully considered to ensure the MMC will have the widest range of compatibility with other agencies, recognizing this as necessary for MMC to remain on the forefront of health information technology.

Moving outward from the ED, the extent of EMR use is varied throughout the rest of the hospital. In the Emergency Department, the EMR includes medications, orders, laboratory results, radiology readings, a basic history/physical, nurses and physicians notes as well as discharge instructions. On the floors, the EMR has laboratory results, radiology readings and other test results, and other parts of the record are still handwritten with easy access. It is part of the Monmouth Medial Center global IT initiative that all areas of the medical center are EMR active by 2011.

Further, meaningful use requirements, with a compliance goal of 2011 at Monmouth Medical Center, include provisions for a physician to take advantage of EHR in their own private practice. Private physician offices and their style of practice are being taken into account as vendors are linked with these clinical partners to create the EMR interface with Monmouth. This linking of vendors and physicians ensures that certified products are used so that information transfer may occur. By 2011, there will be active physician connectivity. Part of this deliberate strategy includes the costs associated with linking physicians and the medical center through EMR. What can be subsidized and what is funded by the medical center or physicians are important factors as work towards this connectivity goal is accomplished. At Monmouth Medical Center, part of the leverage for EHR connectivity to physician offices is physician education of EHR benefits to create behavioral changes. The ability to eliminate potential areas of medical errors, including handwriting and timeliness of orders, gives clear quality markers for both the private physician practice and care provided at Monmouth Medical Center.

In addition, Monmouth Medical Center was recently selected and is currently actively engaged as one of only two hospitals in New Jersey to begin a CMS-funded, 21-month pilot project to test a model of transitioning Medicaid patients who present to the ED with non-emergent care needs to the appropriate primary care setting through collaboration with the FQHC. This data driven pilot has

further integrated electronic referral systems and electronic health records through infrastructure enhancements and the recommendations of State and Federal agencies administering and coordinating the pilot in New Jersey and in 19 other states. Currently, the FQHC clinicians can electronically access previous hospital history and test results for their patients. By 2011, the Monmouth's new CPOE functionality will be fully interoperable between the Emergency Department EDIMS system, and the Long Branch Federally Qualified Health Center, allowing for a truly comprehensive EMR for our patients, as well as CPOE for our physicians and other clinicians, both in the medical center and in private offices.

For patients who use emergency rooms as their primary care provider, we have seen a 70% conversion rate in providing a "medical home" through the FQHC. It decompresses the ED, allowing for more timely care and better allocation of resources for the patients truly needing emergency care, and the electronic aspects of the project help to further streamline costs and enhance patient safety.

Finally, Monmouth Medical Center is currently one of 12 hospitals in the state of New Jersey as part of the Medicare Demonstration Project linked to Gain Sharing with physicians. There is a criterion that allows for the volunteer enrollment of physicians who have specific patient treatment outcomes collected in clinical categories across specialties. As you know, we use information technology to record in a database length of stay, mortality, and readmission rates per physician. Currently, we are examining records from 2007 and 2008. Based on improvements, physicians share in the cost savings the medical center might realize. The first iteration of this demonstration project at Monmouth Medical Center had an increase three times the original physician enrollment since the first gain sharing checks were issued. The second phase of this project, to modify criterion for savings, is currently underway.

CONCLUSION

It is clear to me that the HITECH Act was very timely for Monmouth Medical Center, catching us in stride and greatly facilitating us fulfilling our goals over time as they relate to health information technology. Monmouth Medical Center is working towards becoming a meaningful user but it will take a great deal of effort and funding. However, we feel that HIT is important to the nation's long term objectives of improving quality and reducing cost.

I appreciate the opportunity to appear before you today and would be happy to answer any questions that you may have.

Frank J. Vozos, M.D., FACS
Executive Director
Monmouth Medical Center
300 2nd Avenue
Long Branch, NJ 07740
732/ 923-7504

Mr. PALLONE. Thanks so much, really.

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

Mr. Starnes.

STATEMENT OF GREGORY E. STARNES

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

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

The challenges I have faced during the last 18 months have been the most difficult of my career. In early 2009, my hospital began to feel the effects of the changing economy. July of each year has typically been the month during which I have been able to provide merit pay increases for my dedicated employees. In May of 2009, I informed my employees they would not be receiving any wage increases in July. The hospital finances did not improve in the ensuing months as a local employer with 140 employees relocated to another State. In early October 2009, I conducted numerous meetings with all employees to inform them that I was reducing the work hours by 5 hours per 2-week pay period, which represented a 5 percent decrease in their wages. My managers and I accepted a 10 percent reduction in our salaries. I reduced vacation accruals and temporarily halted the employees' 401(k) match and I eliminated several positions. We saved a great deal of month in the fourth quarter of 2009 yet we finished the year in the red with a net income of a negative $74,000. On January 1, I increased the managers' salaries 5 percent. Since that time there have been no hour or wage increases for anyone. The number of full-time-equivalent employees in September of 2009 was 225. The total now is 195. I represent only one example of many hospitals that have faced those same challenges, hospitals that are within the top three employers in the communities we serve.

We are not just about health care in our communities, we are also about jobs. We are about jobs for nurses, nurse aids, physicians, lab and X-ray technicians, housekeepers, cooks, maintenance workers, therapists and so on, and of course, information technologists. In some of these jobs categories, there are shortages of qualified personnel. In all of these categories, these workers need

the proper tools to do their jobs to the best of their abilities. CT scanners, MRI units, operating room equipment, ambulances, et cetera are hugely expensive. Software, hardware and training are extremely cost. To achieve the expectations of our patients along with those of the governing authorities requires a great deal of money. Awareness of this among our Congressmen and Congresswomen is vital as we endeavor to improve health care in America.

There are 51 critical-access hospitals and another 15 rural hospitals in Illinois out of 200 plus total hospitals. All are taking steps toward meaningful-use criteria. At least 10 of the critical-access hospitals have less than 20 days cash on hand because of the impact of increased Medicaid and self-pay patients. A reasonable estimate would suggest that roughly half of the hospital have inpatient health information systems and two-thirds of them have lab and radiology systems. However, only 20 percent have physicians using computerized physician order entry. The new meaningful-use rule with allow other practitioners to enter orders into the system and that will help but it will also place additional burdens on the hospital staff.

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

At this time my hospital needs a new CT scanner for a minimum of $350,000 because the one we currently have is 8 years old and increasingly unreliable. We also need to buy a digital mammography unit for approximately $350,000 so that women in the community can take advantage of up-to-date technology and so that unit can work with an electronic health records system. There are numerous other needs that are very expensive, and we all face challenges like that already, and I know that we face the acquisition implementation of EHR as well. I believe there may be rural hospitals that will not meet the imposed timeline under HITECH.

Additionally, qualified health IT professionals are in high demand and the supply is currently a problem. So increased need for them in order for hospitals to achieve the IT requirements for EHR systems may present real-time and cost concerns. It is indeed fortunate that there are efforts underway to boost the health IT workforce through funding for community colleges. However, the boost might not materialize in time for hospitals to realize the currently structured incentives for meaningful use. Failure on the part of

some hospitals to arrive at meaningful-use capabilities could jeopardize patient safety.

It is my understanding that assistance to overcome these challenges will be available through the RECs, and I applaud that effort. However, I am concerned as we have seen through other federal offices and programs there will not be a sufficient focus on the challenges——

Mr. PALLONE. Mr. Starnes, I am going to have to ask you to summarize the rest, too.

Mr. STARNES. All right. Thank you.

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

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

[The prepared statement of Mr. Starnes follows:]

July 26, 2010

Honorable Members of the Subcommittee on Health for the Committee on Energy and Commerce in the United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115
C/o earley.green@mail.house.gov

Dear Honorable Members:

My name is Greg Starnes, and I am the Chief Executive Officer of Fayette County Hospital and Long Term Care in Vandalia, Illinois. I have been in health care administration my entire career of 34 years. I consider it an honor to provide this testimony to you for your perusal and consideration on the important matter of the Health Information Technology for Economic and Clinical Health Act (HITECH).

Fayette County Hospital and Long Term Care is a Critical Access Hospital with 25 acute beds and 85 long-term care beds. The hospital was constructed under the Hill-Burton Act in 1955 and was the first fully air conditioned hospital in the nation. The hospital design was an award-winner at the time. Since that time, the long-term care beds were added, and more recently the Imaging, Surgery and Emergency departments were expanded and improved. The facility serves a county of 21,000 people and resides in the county seat of Vandalia with a population of 7,000. The average household income is below the state average, the percentage of elderly in the population is higher than the state average, the unemployment rate is 10%, the number of Medicaid-eligible has increased in the last year, and the numbers of individuals who find themselves with no ability to pay for health care services have also risen. They represent the reality in today's rural health care environment in Illinois.

The challenges I have faced during the last 18 months have been the most difficult of my career. In early 2009 my hospital began to feel the effects of the changing economy. July of each year has typically been the month during which I have been able to provide merit pay increases for my dedicated employees. In May of 2009 I informed my employees that they would not be receiving any wage increases in July. The hospital finances did not improve in the ensuing months as a local employer with 140 employees relocated to Missouri. In early October, 2009, I conducted numerous meetings with all employees to inform them that I was reducing their work hours by 5 per 2-week pay period. That represented a 5% decrease in their wages. My managers and I accepted a 10% reduction in our salaries. I reduced vacation accruals and temporarily halted the employees' 401K match, and I eliminated several positions. We saved a great deal of money in the fourth quarter of 2009, yet we finished the year in the red with a net income of ($74,000). January 1, I increased the managers' hours from 72 per pay period to 76, thereby increasing their salaries 5%. There have been no hours or wage increases since that time for anyone. My number of full-time-equivalent employees in September of 2009 was 225; my total now is 195. I represent only one example of many hospitals that

have faced those same challenges – hospitals that are within the top 3 employers in the communities we serve. We are not just about health care in our communities; we are also about jobs.

We are about jobs for nurses, nurse aides, physicians, lab and x-ray technicians, housekeepers, cooks, maintenance workers, therapists, and so on, and, of course, information technologists. In some of these job categories there are shortages of qualified personnel. In all these categories, these workers need the proper tools to do their jobs to the best of their abilities. CT scanners, MRI units, Operating Room equipment, ambulances, etc, are hugely expensive. Software, hardware, and training are extremely costly. To achieve the expectations of our patients, along with those of the governing authorities requires a great deal of money. Awareness of this among our Congress Men and Women is vital as we endeavor to improve health care in America.

There are 51 critical access hospitals and another 15 rural hospitals in Illinois out of 200 plus total hospitals. All are taking steps toward meeting meaningful use criteria. At least 10 of the critical access hospitals have less than 20 days cash on hand because of the impact of increased Medicaid and self-pay patients. A reasonable estimate would suggest that roughly half of the hospitals have inpatient health information systems, and 2/3 of them have Lab and Radiology systems. However, only 20 percent have physicians using Computerized Physician Order Entry. The new meaningful use rule will allow other practitioners to enter orders into the systems, and that will help, but it also places additional burden on the hospital staff.

Thank you for your support of changes in the final Meaningful Use Objectives. Some of them indeed lessen the burdens for Critical Access Hospitals to achieve those objectives. The loosening of the Computerized Physician Order Entry (CPOE) requirements as well as inclusion of critical access hospitals for Medicaid incentives represent a positive change from the original proposed guidelines. That said, the challenges our hospitals still face should not be underestimated. The capital necessary to procure the software and hardware is still less accessible in today's economy than it was 12 to 18 months ago. In my case the estimated cost for software and hardware necessary to achieve meaningful use criteria will likely be close to $750,000. Training and process changes are likely to cost an additional $50,000 to $100,000. There will also be substantial costs associated with establishing the interfaces to enable all the hospitals' and other providers' systems to connect. These numbers are large for my hospital and for many other hospitals.

At this time my hospital needs to purchase a new CT scanner for a minimum of $350,000, because the one currently in use is 8 years old and is increasingly unreliable. We also need to buy a digital mammography unit for approximately $350,000, so that women in the community can take advantage of up-to-date technology and so the unit can work with an Electronic Health Record System (EHR). There are numerous other needs as well that are very expensive to purchase. Again, I represent merely one example of hospitals that face like challenges already and that now face the acquisition and

implementation of EHR systems. I believe there may be rural hospitals that will not meet the imposed timeline under HITECH.

Assistance for hospitals is available from Regional Extension Centers (RECs) recently established by the Office of the National Coordinator. These RECs are to provide EHR consulting to hospitals but will not include a separate specific focus on the special needs of our rural facilities. Funding for RECs to assist small rural hospital has been increased, but I fear those funds may be under-utilized without a more specific focus.

Therefore, I recommend a change in priority and focus for the REC model by reprogramming a portion of the funding to serve critical access hospitals. Specifically, I support the idea of directing those funds through organizations like the Illinois Critical Access Hospital Network (ICAHN) or the Illinois Hospital Association's (IHA) Small and Rural Hospital section. Many other states have similar organizations that are designed specifically to assist their member hospitals. If a portion of the funds were simply redirected, there should be no additional cost to the overall REC initiative. In some state associations like IHA there may already be some IT consulting services available that could be increased without adding a large number of new IT staff.

Qualified health IT professionals are in high demand, and the supply is currently a problem, so increased need for them in order for hospitals to achieve the IT requirements for Electronic Health Record systems may present real time and cost concerns. It is indeed fortunate that there are efforts underway to boost the health IT workforce through funding for community colleges. However, the boost might not materialize in time for hospitals to realize the currently structured incentives for meaningful use. Failure on the part of some hospitals to arrive at meaningful use capabilities could jeopardize patient safety.

A recent national survey of critical access hospitals conducted by the National Rural Health Association (NRHA) to measure the hospitals' ability to achieve the original proposed meaningful use estimates that only 30 percent of CAHs nationwide would qualify for stage 1 incentives. This survey was completed prior to the revised meaningful use rule, which may render closer to 50 percent of CAHs able to meet the stage 1 incentives.

Ultimately, the most critical benefit to all hospitals and providers achieving Electronic Health Record system functionality is the overall impact to and improvement of patient safety. Without the ability to provide an Electronic Health Record for every patient, medial and medication errors, compromised patient safety, reduced efficiency, decreased patient satisfaction, and a potentially high percentage of implementation failures may become more prevalent. That would work directly against the intentions and goals of the entire initiative and could create a disproportionate sets of issues for rural providers and patients.

To help minimize the burdens rural hospitals, I suggest:

- Provide a broader payment window for hospitals unable to qualify for Stage 1 Incentive payments due to a lack of capital and the barriers faced by rural hospitals and critical access hospitals.

- Reprogram currently available funding for RECs to hospital associations already established to assist their member hospitals. Or a national rural REC office could be created to provide consultation to individual rural hospitals and to current RECs to offer rural insight in their outreach.

Please know that Fayette County Hospital and Long Term Care, along with virtually every rural hospital and provider across the U.S., truly wants to offer patients the benefits of a fully functional Electronic Health Record system. We understand the advantages it can have in reducing overall costs, duplication, and errors while also improving accountability and patient safety. Without a definition of meaningful use that recognizes the unique nature of rural hospitals and providers, however, there is concern that the benefits we pursue may not be realized by rural patients.

Thank you for this opportunity to offer my testimony. I will be happy to answer any questions you might have about any statement contained in this document. I look forward to working with you to ensure that all hospitals and providers, urban and rural, realize the benefits of Electronic Health Record Systems.

Respectfully,

Gregory D. Starnes, MBA
Chief Executive Officer

Mr. PALLONE. Thank you.

We still have another 6½ minutes, so I am going to ask Ms. Bechtel to go and then we will break.

STATEMENT OF CHRISTINE BECHTEL

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

So I am honored to be with you today to discuss the ways in which meaningful use of information technology will benefit patients and their families. That said, our discussion today shouldn't actually be about technology. It should be about the ways in which changes in health care payment and delivery can create the kind of truly patient-centered system that we all envision and that every consumer deserves. That means designing systems around what patients say they want and need to improve their own health outcomes, and what patients want is simple and straightforward. They want their doctors to talk to each other. They want information about their conditions. They want providers to know them well enough to make treatment recommendations that actually make sense for them and they want their care team to have the information and support that they need to do the best job they can. Technology plays a critical role in delivering this kind of patient-centered care. It cannot be done right, done well or done consistently without interconnected health IT, and the regulations issued by the Administration on meaningful-use lay the groundwork for doing just that.

I would like to highlight some of the ways that the meaningful-use program will result in tangible improvements for patients and families by sharing with you the story of Susan Crowson, who is a family caregiver from Maryland. Susan looks after her father, Pop, who has Alzheimer's disease, heart arrhythmia, prostate problems, low blood platelets and is susceptible to other infections. He sees a primary care physician, a cardiologist, a urologist, a hematologist and a neurologist. Each monitors and treats a separate problem and yet they don't talk to each other. So Susan had to build a spreadsheet to keep track of it all. She leaves copies with each doctor and asks that Pop's records be sent to his primary care physician and his other specialists, but it is rarely done. When she takes her dad for lab tests, she is the one who makes sure that each doctor gets the results or it just doesn't happen. Pop takes there prescription drugs, two over-the-counter drugs and vitamins as well as occasional antibiotic. These drugs are prescribed by different doctors. When his doctors prescribe a drug, they actually tell Susan to make sure that she checks with Pop's other doctors about potential drug interactions.

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

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

Stage 1 of meaningful use also builds the foundation for overall improvements in the quality, safety and efficiency of care. For example, it requires the collection of race, ethnicity, preferred language and gender data so that we can identify and target health disparities. It asks physician meaningful users regardless of specialty to focus on hypertension, smoking and obesity so that we can better address the public health challenges are driving the increase in chronic conditions and causing costs to skyrocket, and it advances an important set of criteria for protecting the privacy and security of health information.

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

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

[The prepared statement of Ms. Bechtel follows:]

Testimony of Christine Bechtel
National Partnership for Women & Families
Hearing on Implementation of the HITECH Act
U.S. House of Representatives
Committee on Energy and Commerce
Health Subcommittee
July 27, 2010

Good afternoon Mr. Chairman, Congressman Shimkus and members of the subcommittee. My name is Christine Bechtel and I am Vice President of the National Partnership for Women & Families. Just over a year ago, I was also appointed by the Government Accountability Office (GAO) to serve as a consumer representative on the Health IT Policy Committee.

The National Partnership is a non-profit, non-partisan consumer organization with almost 40 years of experience working to make life better for women and families by promoting access to quality health care, fairness in the workplace and policies that help women and men meet the dual demands of work and family. As you know, health care is central to the well-being of women and families – it is a key determinant of their quality of life, their economic security, and their ability to thrive, prosper and participate in our society.

We are privileged to lead two important coalitions of consumer organizations dedicated to changing the way health care is organized, financed and delivered. The Consumer Partnership for eHealth (CPeH) and the Campaign for Better Care together include more than 150 consumer and patient groups working to ensure that implementation of both the HITECH Act and the health reform law result in higher quality, more patient-centered care, fewer disparities and better outcomes for everyone.

Health information technology (IT) plays a critical role in achieving these goals, and I am honored to be with you today to discuss the ways that the Meaningful Use of health IT will benefit patients and their families.

PATIENT-CENTERED CARE

That said, our discussion today shouldn't be about technology. It should be about the ways in which changes in health care payment and delivery can create the kind of truly patient-centered system we all envision, and that every consumer deserves.

That means designing systems around what *patients* say they want and need to improve their health outcomes. And what patients want is simple, sensible and straightforward:

- They want their doctors to talk to each other.
- They want to know that all the members of their care team have the information and support they need to do the best job they can.
- They want information that helps them better understand their conditions and care effectively for themselves and their family members.
- And they want a health care provider who really knows them enough to recommend treatments that make sense based on their unique needs, preferences and life circumstances.

The role of technology in delivering on this kind of patient-centered care cannot be overstated. It cannot be done right, done well or done consistently without interconnected health IT.

And the good news is, although consumers may not understand all the details of the technology and its implementation, there can be no doubt that they understand the potential that it holds. Last year, the National Partnership commissioned public opinion research with patients and caregivers, and it was clear that they quickly and intuitively recognize that health IT leads to improved communication and coordination in health care, and that these improvements lead directly to fewer medical errors, lower costs and better health outcomes. They see the benefits technology has brought to other areas of their lives and see how private and secure health IT can improve our nation's health system.

WHY THIS MATTERS

We are convinced that the regulations recently released for the Meaningful Use of health IT lay the groundwork for doing just that. By making some reasonable changes in finalizing the criteria, but standing firm against industry pressure to weaken them substantially, the Administration put us on a path to improve patient safety and coordination of care, and to make our health system more efficient. This, I believe, is what Congress intended when you coined the term "*meaningful* use." We will all benefit as private and secure electronic health records become the norm in the United States.

To that end, I'd like to highlight some of the ways that the Meaningful Use program will result in tangible improvements for patients and their families by sharing a brief story that illustrates why these regulations matter so much.

Susan Crowson is a family caregiver from my home state of Maryland who is part of our Campaign for Better Care. She looks after her father, "Pop," who has Alzheimer's disease, heart arrhythmia, prostate problems, low blood platelets, and is highly susceptible to other infections. He sees a primary care physician, a cardiologist, a urologist, a hematologist and a neurologist. Each monitors and treats a separate problem, and yet they don't talk to each other.

So Susan had to build her own spreadsheet to keep track of it all. She's given copies to members of her family and leaves copies with each doctor she visits. Every time she takes Pop to the doctor, she asks that his records be sent to his primary care physician and other specialists, but it's rarely done. When she takes her dad for lab tests every two months, she's the one who makes sure each doctor gets the results — or it doesn't happen.

Pop takes three prescription drugs, two over-the-counter drugs, and vitamins every day, as well as occasional antibiotics. These different drugs are prescribed by different doctors. When Pop's doctors prescribe a drug, they tell Susan to check with his other doctors about potential drug interactions.

By no means is Susan's situation unique. In fact, it is common. We talk every day with patients, caregivers and consumer advocates, and hear time after time about the challenges associated with gathering and updating hundreds of pages of medical records – if they can get them at all -- and toting them from one doctor to another, always knowing that no provider is likely to have full medical histories and test results. While this is extraordinarily difficult for patients, the problems are compounded when a family member tries to coordinate care for a relative who cannot navigate the health system on his or her own.

THE IMPACT OF MEANINGFUL USE FOR PATIENTS AND FAMILIES

Mr. Chairman, I am confident we can help Susan and the millions of patients and families like hers to get better care by leveraging the requirements that are now part of the Meaningful Use program.

This incentive program is transformative, yet achievable. By focusing on improving health care and outcomes, rather than simply automating processes and digitizing data, Meaningful Use will be a significant boost to efforts to successfully modernize our health care system. The new regulations are strong, sensible and patient-centered – just what the nation needs.

With these regulations in place, Susan wouldn't have to keep a spreadsheet to track Pop's care. If all the members of Pop's care team were Meaningful Users of health IT:

- They would maintain an up-to-date list of all of Pop's health conditions, diagnoses and medications;
- Susan would receive a summary of the care Pop received within three days of a visit to each physician;
- If Pop was admitted to the hospital, Susan could request an electronic copy of his discharge instructions; and
- If Pop's doctors chose to give her timely access to his health information, which is optional under Stage 1, Susan would be able to view his medical information at any time. This will -- and should -- become a requirement in Stage 2.

Susan also wouldn't have to ask all of Pop's doctors whether his medications interact. Under Meaningful Use, Pop's care team would:

- Maintain a list of his active medications and medication allergies;
- Check those lists for drug-drug interactions and drug-allergy problems; and
- Have the option to perform medication reconciliation each time Pop transitions from one setting to another. We are hopeful that most providers will.

Finally, Susan wouldn't bear the entire burden of ensuring that all of Pop's doctors have the information they need to do the best job they can. Meaningful use lays some important groundwork for improving care coordination and communication:

- Any time Pop transitions from the hospital to home, a Summary Care Record would be sent to his primary care physician;
- Susan would receive reminders about his follow-up care, and education resources about Pop's conditions; and
- Pop's doctors would have to perform at least one test to demonstrate that they can send his clinical information electronically to another member of his care team. While this may not sound like a lot, it reflects the overall state of communities' ability to exchange health information electronically. We know that the Administration is working furiously on building the kinds of policies, standards and services we need to truly create an interconnected, information-rich, *national* health system.

Stage 1 of Meaningful Use also builds the foundation for overall improvements in the quality, safety and efficiency of care. This foundation is critical to helping providers today figure out how to change the way they practice tomorrow, as the health reform law brings new payment and delivery approaches. Specifically,

- The Rule requires collection of structured data on race, ethnicity, preferred language and gender (RELG). We can't eliminate health disparities if we don't have the data that allows us to first identify and target them.

- The Rule asks all Meaningful Users to report electronically on the quality of their care. All physicians will report on measures related to hypertension, smoking and obesity. The fact that all physicians who are Meaningful Users – regardless of specialty – will focus on these areas is a major step toward addressing the public health challenges that are driving a dramatic increase in chronic conditions which, in turn, are causing health costs to skyrocket.

- Finally, the rule advances a set of important criteria for protecting the privacy and security of health information. Certified EHRs will need to have key data security functionalities and standards; and providers will have to both conduct security risk assessments **and** correct identified deficiencies. In Stage 2, CMS should reconsider the HIT Policy Committee's recommendation to make compliance with state and federal privacy laws a mandatory criterion.

ENSURING SUCCESS

Building a patient-centered, HIT-enabled health care system requires more than just incentive payments to doctors. Clinicians need access to hands-on help, best practices, and information that supports them in redesigning the way they deliver care on a daily basis. Congress recognized this important fact when you authorized federal programs that provide a range of resources focused on outreach, education, and charting a path for the future:

- Regional Extension Centers will deliver outreach, training and support services to assist providers – especially those in small and rural practices – in adopting EHRs, giving them the information and guidance they need to implement and use health IT effectively. The centers will play a crucial role at the local level, ensuring that incentive dollars do in fact result in benefits for providers, patients and the health system as a whole.

- Beacon Community Program. The communities that received funding through this program are at the cutting edge of EHR adoption and health information exchange, and will serve as models that show us the path toward a high-performing health system. They will demonstrate how health IT can lead to sustainable and measurable health outcomes improvements, and in so doing will inform future stages of Meaningful Use.

- Curriculum and Workforce Development Programs. None of this can be done effectively without an adequately trained workforce. Colleges and universities have been awarded grants to meet the growing demand for skilled health IT specialists, and curriculum development centers will support these educational institutions. Without a doubt, patients in all areas of the country will directly benefit from greater numbers of health care professionals trained in the meaningful use of health IT.

Finally, as we focus on helping clinicians adopt EHRs, we must also ensure patients understand, trust and embrace the benefits of a modernized system. Doing so requires two things. First, that the meaningful use program is actually meaningful to patients – that is to say that they see a real difference in the way their care is delivered. Second, we need to begin a national dialogue about the value of health IT, including the ways in which patients' privacy will be protected and how they can exercise their rights in an electronic environment. Congress again wisely understood this need, and we are eagerly awaiting the start of the public education campaign called for in HITECH.

FORGING AHEAD

There is no doubt that the regulations released last week are a great beginning for patients and families. But our work on the Meaningful Use of health IT is far from done. For consumers, there are no more pressing challenges than improving care coordination and communication. For Meaningful Use to pay big dividends for the taxpayers who fund it, Stage 2 must prioritize and enable the robust exchange of clinical information in a private and secure way across all the providers and settings involved in the patient's care.

Stage 2 should also require all providers to give patients timely, ongoing access to their own health information and – most importantly – to do so in a way that is portable, so patients can assemble all their information in a secure place of their choosing. This is key to facilitating effective self-management, the ability to correct errors and better communication with care teams.

Finally, we must ensure that health IT is used effectively to improve outcomes. The measure of patient-centered care is whether patients' health and well-being actually improves, their quality of life is as good as it can be and they have the best possible experiences in the health system. Achieving this will require a set of increasingly robust quality measures that are oriented toward measuring health outcomes, functional status and patient and caregiver experiences, so we can better understand what patients need and how to continually improve their experiences and their care.

As with our current efforts, future criteria should be driven by the goal of high quality, patient-centered care. After all, health care transformation is not about money and it is not about technology. It is about people, and leadership, and we thank you for yours.

Mr. PALLONE. Thank you.

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

[Recess.]

Mr. PALLONE. The Subcommittee on Health will reconvene, and we left off with Ms. Bechtel, so Dr. Goertz, you are next.

STATEMENT OF ROLAND A. GOERTZ

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

Nearly one in four of all office visits is made to family physicians. We provide more care to America's underserved and rural populations than any other medical specialty. Our commitment to improving patient care and clinical outcomes has long made us supporters of HIT. We believe that the recent meaningful-use regulations will support what the AAFP already has been doing for many years. Our focus has been to ensure that the meaningful-use rules are achievable by physicians in small- and medium-sized practices and also improve patient care. Our members want to accomplish what Congress intends. Fifty-nine percent of our members currently have electronic health records but their use of it varies greatly. We need to help the rest purchase IT, encourage those who have it to become more comprehensive users of it and have all begin to use it more effectively. We ask that your committee ensure that the first rounds of reporting and incentives from CMS be both consistent and reliable.

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

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

Let me make two general observations about adoption of HIT. One, physicians coming out of residency today expect to use HIT and do so almost automatically. The issue of adoption is a generational one and will resolve over time. However, we are in the

middle of a significant health care transition and must assist all physicians by supporting the regional extension programs, beacon communities, medical-home pilots and dissemination of best practices.

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

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

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

[The prepared statement of Dr. Goertz follows:]

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Before the

House Energy and Commerce Subcommittee on Health

Regarding
Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act

Presented by

Roland A. Goertz, MD, MBA, FAAFP

July 27, 1:00 pm

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Chairman Pallone, Ranking Member Shimkus and members of the Subcommittee, I am Roland A. Goertz, MD, MBA, President-Elect of the 94,600 members of the American Academy of Family Physicians (AAFP). As the CEO and Executive Director of a Federally Qualified Health Clinic (FQHC) in Waco, Texas, I am pleased to be here today to discuss the importance of health information technology and its role in transforming health care in the US. My experience should provide a window into how HIT can be utilized by small practices, rural providers and those who serve a variety of populations and how the HITECH subsidies will help.

Background

Let me begin by giving you a little background about the AAFP. Founded in 1947, it is the only medical society devoted solely to primary care. Nearly one in four of all office visits are made to family physicians. That is 208 million office visits each year – nearly 83 million more than the next largest medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty.

In the increasingly fragmented world of health care where many medical specialties limit their practice to a particular organ, disease, age or gender, family physicians are dedicated to treating the whole person across the full spectrum of ages. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care.

Due to the number of patients family physicians see each year and the wide range of medical services they provide to their patients, the AAFP has long been committed to health information technology as one means to improve quality and cost-effectiveness of health care delivery in the US.

AAFP's Long-term Commitment to HIT

The AAFP worked closely with Congress to craft the *Recovery Act* provisions on health information technology. The *Recovery Act* makes an unprecedented investment in health information technology and reflects an understanding of HIT as a critical component in a reformed health care system. The AAFP has supported the provisions that would allow our members, and other physicians, to purchase HIT systems and use them effectively.

We believe that the recent "meaningful use" regulations will broadly support what the AAFP already has been doing for years to transform health care. The new federal regulations will influence both how EHR technologies are used and the nature and features of electronic health records (EHR) technologies themselves, perhaps for the next generation. They provide an opportunity to lay a foundation for improving the quality, efficiency and safety of the nation's health care through the use of health information technology.

The AAFP's main priority has been that the proposed criteria and timeline in the "meaningful use" rules are achievable for physicians in small- and medium-sized practices so that they can qualify for the incentive payments and the rules could then accomplish what Congress intends. We believe the recently-issued rules will be achievable, but they do require significant effort by physicians and their practices.

Given the past efforts of the Centers for Medicare and Medicaid Services in administrating incentive programs, such as the Physicians Quality Reporting Initiative, many physicians are not reassured that they will receive the bonus if they attempt to participate in the program. We ask your committee to help make sure that CMS delivers on the execution of this program. If the first rounds of reporting and incentives do not go smoothly, many physicians will turn away from this program.

The AAFP is proud of the fact that 59 percent of our members currently use electronic health records; 44 percent use e-prescribing; and nearly 25 percent use EHRs for patient registries and tracking their patients to ensure they are receiving the preventive care they need. To the extent that the rule defines these activities as "meaningful use," significant numbers of our members are already effectively utilizing HIT. Nevertheless, we need to help the remainder of our members purchase EHRs, encourage those who are using the technology only partially to become more comprehensive and have everyone begin using it effectively.

Our FQHC's Experience with HIT

Let me use our FQHC's experience with health information technology to exemplify EHR's use and importance in a real-life setting.

Our FQHC purchased an electronic health record system 14 years ago as a result of the extraordinary vision of the CEO at the time. Over the past decade, we have found that its use and application have led to significant clinical outcomes that have shown better quality and efficiencies in patient care. Right now, we are using our EHR to address a number of clinical issues, from immunizations to diabetes.

Our FHQC is based in Waco and has 13 sites, two of which are in rural communities around the area. All sites communicate wirelessly, which is less costly. The number of physicians in each site varies from 2 physicians, a nurse practitioner and one physician assistant, to a larger site that includes a resident training program, behavioral health and dental services.

The mission of FQHCs is to provide health care to those under 200 percent of poverty, those covered by Medicaid and those who are dual eligible. In total, our FQHC serves approximately 50,000 people with those characteristics. As a result of this diversity of populations and settings, we have learned a great deal about the use of EHRs

Adoption of HIT: What We Have Learned

We often are asked about our experience with encouraging our physicians to adopt HIT. When we purchased our EHR system 14 years ago, clearly, we were an early adopter of a new technology. A number of our physicians were uncomfortable with computers, we were in a rural area and we took a fairly aggressive and committed approach to make it work. Now, however, despite that initial reluctance by some people, our surveys indicate not one of our providers would return to paper records. They have seen how HIT use has improved patient care and increased their effectiveness.

In Texas, the majority of physician practices include 1-5 physicians. Nationally over 25 percent of family physicians are in practices of 1-2 physicians. Clearly, these are the small- and medium-sized practices that we in Texas, and the AAFP nationally, want to encourage to adopt HIT. While some of these physicians have purchased EHRs over the years, others have been waiting for the incentives in the HITECH Act to allow them to make the investment.

Small- and medium-sized practices, particularly those in rural areas, are critical to making HIT work in this country. Practices that are not linked to a larger system typically find it the most difficult to make the financial investment and changes necessary while running busy practices operating on small margins.

These practices also struggle to find the technical assistance to implement and maintain their new IT systems. Without assistance in this regard, it is difficult, if not impossible, to achieve the desired outcomes of meaningful use. The establishment of the regional health information technology extension center program will be critical for success by these practices. We are hopeful that the regional extension centers will be able to provide such assistance, but we are concerned about their capacities to provide these critical services.

Given the criticality of technical assistance to practices, we ask that your committee monitor closely the Office of the National Coordinator's implementation of the regional extension program to assure its success and expansion of these assistance programs as meaningful use progresses.

Generations in Transition

We have made at least two observations about encouraging different sizes and types of practices to make the leap and purchase EHR systems. The first observation is quite straightforward: physicians coming out of residency today and over the last decade simply expect to use HIT and do so automatically. Unsurprisingly, those physicians who have practiced longer, and whose average age nationally is 51, were not exposed to computers at an early age – as were younger physicians - and may not wish to change their patterns at this point in their career.

Consequently, the issue of whether or not to adopt HIT is partially a generational one and will resolve itself over time. During this period, however, I expect that some physicians will choose to step off the medical path. That is their choice. While I do not know how long it will take, the current issue slowly will disappear and physicians and patients will reap the benefits of improved patient care and efficiency.

Nevertheless, we are in the middle of a significant transition in health care in this country. We must assist physicians as they make this change. Many practices are interested in purchasing HIT but have not seen it in action. Our experience is that showing physicians from all practices how they can use EHRs to transform their patient care makes them very receptive.

Specifically, provisions in the HITECH Act, such as the regional extension centers and the Beacon Community funding programs will serve as a bridge for both new and older physicians to effectively use health information technology. The regional extension centers were established to provide technical assistance and guidance to primary care providers so that they can become meaningful users of HIT. The Beacon program will provide funds to communities to help them build their infrastructure and then disseminate best practices to the rest of the US. Both programs will help support physicians in their efforts to "meaningfully use" HIT. Discovering and disseminating best practices on achieving high quality, safety, and efficiency is critical to get the potential benefits out of the health information technology investment. We ask that your committee continue to support pilots, around the patient centered medical home and advanced use of health IT, and other projects that help in this discovery and dissemination of best practices.

The Importance of Resources

As stated above, our second and more important observation is that solo, small, rural practices, in particular, are extremely short of time and dollars. Under those circumstances, it is nearly impossible to put aside savings with which to purchase HIT. In addition, practices implementing HIT see fewer patients and earn less money as they prepare their practice for an EHR and then select, implement, maintain and "meaningfully use" a system. As a result, we strongly support these important HITECH Act incentives.

We ask that your committee fight for appropriate payment for family physicians and other primary care physicians as they invest heavily in transforming their practices for the future – investments that extend well beyond HIT implementation – all of which are critical for improved quality and cost efficiency of care. In addition, practices are at their maximum capacities for change, and we ask that your committee not make additional requests of these physicians during this transition and even look at the required adoption of ICD-10 as something to delay.

We support the "front-loaded" aspect of the HITECH incentive payments. These dollars will allow physicians to purchase the hardware, software and maintenance programs that are crucial to implementing a successful HIT program. While hardware costs have decreased over time, software and maintenance costs have not. Our data shows that an average EHR system costs $40,000, a steep price for small- and medium-sized practices, not including the thousands lost in decreased productivity during the transition.

Specifically, we realize that meeting the goal of "meaningful use" will mean more investment, both in time and money, than simply implementing any EHR on the market. And, staying current with "meaningful use" requirements likely will mean incremental updates in EHR software and interfaces, which will be ongoing costs to practices.

Consulting and training expenses also must be considered in addition to the pure hardware and software costs and issues. The workflow redesign required to realize the true benefits of EHR adoption and "meaningful use" are foundational changes within the organization that take careful planning, focused effort and active management. Physicians will need to use these dollars to engage experienced, successful and truly independent consultants to help them chart this course.

In sum, the funding provided in the HITECH Act is vital. Physicians deeply appreciate the assistance on purchasing the systems and beginning to make practice changes.

Effect of HIT on Federally-Qualified Health Centers

Health centers must be open to all, regardless of one's ability to pay and the health center's board must be made up of a patient majority. Health centers are not for profit entities serving 20 million patients in over 7,500 communities across the country. In my state of Texas, 57 health centers serve just over 800,000 patients. Meeting "meaningful use" requirements will be a significant change for most federally-qualified health centers. FQHCs will need to work with networks or regional health information organizations to share important information and also provide patients with electronic access to their health records. Both of these issues will require us to develop software, as well as ensure the privacy of patient records. Furthermore, the "meaningful use" rules will change most FQHC's workflow patterns, and, more importantly, report compliances with these regulations to CMS. Nevertheless, these requirements will allow FQHCs ultimately to successfully coordinate and improve the care they provide their patients.

Conclusion

Health care is a significant component of our economic system. While health information is only one portion of this highly complicated industry and investment in HIT at the practice level is critical to improving health care for our patients, will

reduce costly medical errors, can help patients manage their health care more efficiently, and will contribute to the nation's economic recovery.

I would be happy to answer any questions.

Ms. SCHAKOWSKY. [Presiding] Thank you, Goertz.
Dr. Winkleman.

STATEMENT OF MATTHEW WINKLEMAN

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

One of the obstacles many physicians cite in the decision to employ an electronic record is the initial upfront cost. Not only is the software, hardware and necessary infrastructure costly but the process of seeing patients at least in the initial weeks of transitioning requires changes in work flow that will likely decrease efficiency and the number of patients seen. As you are all aware, under our current reimbursement system, fewer patients means less added to the bottom line, and as a result, many physicians calculate they cannot afford the initial financial investment. This is especially true for physicians like myself who practice in rural areas where the average payer mix includes minimum commercial insurance and where profit margins may already be thin.

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

The benefits of EHR use, as I said, are significant. At a time of great uncertainty within the general health care industry, at least one thing seems clear to me: technology will have a role in helping us provide the kind of high-quality, safe, efficient care our patients deserve. On nearly a daily basis, my EHR helps me avoid prescribing a medication to a patient because they have an allergy to it, allows me to print out materials for patients to help them understand their diagnosis and reminds me to order a mammogram on a 55-year-old patient who came in only for a sore throat.

It is not uncommon for me to see patients struggling to manage six to eight medications, caring for three to four chronic diseases. Medicine is complex, and the reality is that even the most astute of clinicians can benefit from the safety checks provided by an electronic health record. Furthermore, while the individual patient benefits from the improved safety that stems from use of an EHR,

my practice has begun to see the benefits to the population as a whole. With the use of our EHR, we were recently able to generate a report of all the diabetic patients from the practice's census who had not received appropriate follow-up and proactively schedule an office visit to get them back in, giving them a much greater chance of avoiding the costly complications that can result from diabetes. Additionally, after the recently controversy surrounding the diabetes drug Avandia, we were able to generate a list of all of our patients receiving this medication within a matter of only minutes. These types of things would have been nearly impossible with a paper system.

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

In summary, as a rural family physician practicing with an electronic health record, I have seen the benefit they can provide by helping improve safety, increase compliance with recommended preventative care and proactively manage chronic diseases. My practice is located in a county ranked by a recent Robert Wood Johnson Foundation study as 98th out of 101 in Illinois with regard to the health of its population and many of the neighboring counties were also near the bottom of that list. I am optimized that the meaningful-use incentives and the work of the regional extension centers can help providers in rural areas like Harrisburg to begin not only to take advantage of health information technology but recognize it as another instrumental tool in the pocket of their white coats. I am excited about what the future holds and look forward to the next steps in the process as we move even further forward in connecting providers to allow the exchange of health information.

Thank you for the opportunity to provide testimony today.

[The prepared statement of Dr. Winkleman follows:]

Testimony of Matt Winkleman, MD,

before the House Committee on Energy and Commerce

Subcommittee on Health

Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act

July 27, 2010

Chairman Waxman, Ranking Member Barton, Chairman Pallone, Ranking Member Shimkus and other distinguished Members of the Committee, let me begin by thanking you for the opportunity to provide testimony today.

My name is Matt Winkleman. I am a family physician practicing in Harrisburg, Illinois. Our community is in rural southern Illinois and has a population of about 10,000. I practice full time and am one of the physician owners of Primary Care Group in Harrisburg, and we serve patients not only Harrisburg but from several surrounding communities and rural counties. Our practice is a rural health clinic that includes eight primary care doctors, five mid-level providers and a general surgeon. In total, the clinic employs around 50 people. I'm honored to share with you today our experience with an electronic health record and a little about how it impacts our practice and the care we provide to our patients.

One of the obstacles many physicians cite in the decision to deploy an electronic record is the initial upfront costs. Not only is the software, hardware and necessary infrastructure costly, but the process of seeing patients in the initial weeks of transitioning to use of an electronic record requires changes in workflow that will likely decrease efficiency and the number of patients seen daily. As you're all aware, under our current reimbursement system, fewer patients seen means less added to the bottom line, and as a result, many physicians calculate that they cannot afford the initial financial investment. This is especially true for physicians like myself who practice in rural areas where the average payor mix includes minimal commercial insurance and where profit margins are already thin.

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And those benefits of EHR use, as I said, are significant. At a time of great uncertainty within the general healthcare industry, at least one thing seems clear to me: technology will have a role in helping us provide the kind of high quality, safe, efficient care our patients deserve. On nearly a daily basis, my EHR helps me avoid prescribing a medication to a patient because they have an allergy to it, allows me to print out materials for patients to help them understand a diagnosis, and reminds me to order a mammogram on the 55 year old patient who only came in for a sore throat. It is not uncommon for me to see a patient struggling to manage six to eight medications and three to four chronic diseases. Medicine is complex, and the reality is that even the most astute of clinicians can benefit from the safety checks provided by an electronic health record.

Furthermore, while the individual patient benefits from the improved safety that stems from use of an electronic record, my practice has begun to see the benefits to the population as a whole. With the use of our EHR, we were recently able to generate a report of all of the diabetic patients from the practice's census who had not received appropriate follow up and proactively schedule an office visit to get them back in, giving them a much greater chance of avoiding the costly complications that can result from diabetes. Additionally, after the recent controversy surrounding the diabetes drug Avandia, we were able to generate a list of all of our patients receiving this medication within a matter of only minutes. These types of things would have been nearly impossible with a paper system.

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place which foster the use of technology in such a way that it truly benefits patients and provides the most value to the physician when they're making care decisions. For this reason, while I am not generally an advocate of large scale government management of healthcare, I do think this is an area where focused guidance steering the medical community is absolutely needed.

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Thank you for the opportunity to testify.

Mr. PALLONE. Thank you, Dr. Winkleman.
Dr. Tullman.

STATEMENT OF GLEN E. TULLMAN

Mr. TULLMAN. Actually I am not a doctor.
Mr. PALLONE. Mr. Tullman, CEO Tullman.
Mr. TULLMAN. Chairman Pallone, Ranking Member Shimkus and other distinguished members of the committee, thank for the opportunity to testify today. My name is Glen Tullman and I serve as the Chief Executive Officer of Allscripts. Allscripts is the largest provider of electronic health records, electronic prescribing, practice management software and other software that helps physicians manage their patients. More than 160,000 physicians, which is one-third of all practicing physicians outside the four walls of the hospital, use Allscripts software along with 800 hospitals and over 10,000 other health care providers in post-acute care facilities and home care agencies to manage their patients. Allscripts solutions automate daily activities and connect their clinical and business operations.

It is now 17 months since the passage of the American Recovery and Reinvestment Act and it is clear that health care information technology as an industry is forever changed. It is my belief that we are at the beginning of the single fastest transformation of a major industry in the history of our country. Congress and the Administration in a sign of true leadership have provided an investment in technology that will lead to the delivery of better care for all Americans, improve patient safety and deliver significant savings due to efficiency.

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

Allscripts have committed extensive resources over the past 17 months to educating all of these groups, not just our clients, about meaningful-use incentives. We have hosted hundreds of free educational sessions across the country and webcasted many more, and in 2 weeks since the release of the final rules on July 13th, we have already provided educational content to thousands of webcast attendees. We expect our educational efforts to continue as we work closely with regional extension centers in the coming months and years.

The HITECH incentives had a measurable stimulative effort on our business in three ways. First, inquiries about our electronic health records have been at record levels since the initial passage of ARRA. Second, we have increased our annual R&D expenditures a full 25 percent from $72 million to $90 million, which will help drive innovation into the industry. And third, we have hired more

than 560 people since the passing of ARRA with plans to hire several hundred more in the next year. These are high-paying technology-centered jobs, just the kind of jobs that the American workforce needs.

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

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

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

In summary, the final rule on meaningful use will result not only in a higher number of providers participating in the incentive program but more importantly higher quality and safer care for patients. We expect most providers not only to meet but to exceed the requirements of meaningful use, which we call meaningful value, by doing more than the minimum. We have key clients across the country who are doing just that. For example, the University of South Florida and Wellspan in Pennsylvania are both using electronic health records to deliver better diabetes care and better inform patients. Sharp Healthcare in San Diego is approaching 90 percent electronic orders. Heritage Valley Health System in Pittsburgh is writing 100 percent of their prescriptions electronically and there are a host of others who are leading the way. We also see leaders like North Shore Long Island Jewish, Hartford Hospital and the University of Massachusetts, who are leading the way by connecting their communities for better care with the goal of one patient record.

Your actions have served to both encourage and accelerate all of these activities and to spur other organizations to take similar actions. As the technology becomes part of the regular work flow and electronic health records provide critical information, we will see that meaningful use is essentially a jumping-off point, ultimately

resulting in the connected system of health that we are all working towards.

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

[The prepared statement of Mr. Tullman follows:]

Testimony of Glen Tullman,

Before the House Committee on Energy and Commerce

Subcommittee on Health

Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act

July 27, 2010

Chairman Waxman, Ranking Member Barton, Chairman Pallone, Ranking Member Shimkus and other distinguished Members of the Committee, thank you for the opportunity to share with you today our perspectives on the implementation of the HITECH Act.

My name is Glen Tullman, and I am the Chief Executive Officer of Allscripts. Allscripts is the largest provider of Electronic Health Record and Practice Management software physicians and caregivers use to manage patients. More than 160,000 physicians (which is one-third of all practicing physicians outside the hospital), 800 hospitals and many thousands of other healthcare providers in clinics, post-acute care facilities, and homecare agencies utilize Allscripts solutions to automate their daily activities and connect their clinical and business operations. Allscripts is also the largest provider of ePrescribing Solutions, and through our revenue cycle management clearinghouse, we process more than half a million claims, remittance and eligibility transactions each year.

It is now 17 months since the passage of the American Recovery & Reinvestment Act, and it is clear that the health information technology industry is forever changed. It is my belief, in fact, that we are at the beginning of the single fastest transformation of a major industry in the history of our country. Congress and the Administration, in a sign of true leadership, have provided an investment in technology that will lead to the delivery of better care, yield significant savings due to efficiency improvements, and markedly improve patient safety. I speak to hundreds of healthcare professionals across the spectrum of care, and it is clear that the Meaningful use incentives in the Stimulus package are an essential component to the sea-change in healthcare that will benefit us all.

It goes without saying that healthcare is complex. Allscripts is unique is that we serve the entire continuum of care, from single primary care physician practices in rural geographies, mid-sized specialty and sub-specialty practices in suburban towns, Federally Qualified Health Centers in underserved environments, multi-specialty clinics, Emergency Department physicians and some of the most recognized and prominent healthcare organizations across the country. Each one of these

providers is someone that HITECH is intended to motivate to either move forward with health IT utilization or expand use already underway.

HITECH and the implementation of an Electronic Health Record are both complex. To help our clients understand the many nuances of the legislation and resulting regulatory activity, along with the steps to take to easily implement an EHR, Allscripts has committed extensive resources over the last 17 months to educating the larger provider community—not just our clients—about the Meaningful Use incentives. We have hosted hundreds of free educational sessions across the country, as well as numerous webcasted versions, and we launched the Allscripts Advocacy Center in early 2010 to facilitate open lines of communication between our clients and Members of Congress and the Administration. In the two weeks since the release of the Final Rules on July 13th, we have already provided educational content to thousands of webcast attendees. We also look forward to working closely with the Regional Extension Centers across the country as they move forward with their efforts to educate healthcare professionals about the importance of health information technology.

Most telling, however, is that inquiries related to our products have been at record levels since the initial passage of ARRA, with the legislation sparking interest in Electronic Health Records among physicians that hadn't considered them before and accelerating implementations for those who had planned to transition a few years down the road. The HITECH incentives have certainly had a simulative effect on our business and led to significant job creation. At Allscripts, we have increased our annual R&D investment a full 25% from $72 million to $90 million, and we have hired more than 560 people in the time since ARRA passed, with plans to hire several hundred more in the next year. These are high-paying technology centric jobs—just the kind the American workforce needs.

The change is also going to lead to market adjustments designed to better serve physicians and hospitals. Our proposed merger with Eclipsys Corporation, a leading hospital software company, is a good example. It's clear that healthcare stakeholders understand the need to connect care wherever it is delivered, whether in a hospital, multi-specialty group, home health environment or in small, independent physician practices.

Even more importantly, though, our clients are also hiring directly as they work to ensure success in their health IT adoption efforts. For example, Denver-based Catholic Healthcare Initiatives, which is making a major investment in health IT, in part spurred by the Meaningful Use incentive program,

has announced that they will be hiring 200 health IT professionals over the next year (100 in the next three months alone) and we have many other clients with similar plans.

Generally, now that the Final Rule is out, the physicians and hospitals among our client base are pleased. The uncertainty about Meaningful Use has been removed, and we can now move forward on getting electronic health records installed. In addition, many of the changes that the provider community requested during the comment period were incorporated into the Final Rule, and the sense is that this process was a positive example of a productive public / private partnership. Many physicians particularly appreciate the flexibility that has been added to the regulatory process related to what constitutes Meaningful Use.

The entire debate also served to give physicians, hospitals and other provider organizations a greater appreciation for the critical role health IT will play in their ability to participate in the delivery system reform efforts that are and will increasingly become a key part of our healthcare system. Healthcare is about information, and we simply can't address the key issues of quality, cost and waste without having the information available to make better decisions. New innovative initiatives like the Patient Centered Medical Home and Accountable Care Organizations, as well as a focus on performance, not procedures, will require better information. We believe that, in part due to the encouragement from you, Electronic Health Records are not only tools that physicians will need to have but that they will want to use to deliver world class care.

I would also encourage the Committee to build on the success to date in a few ways. You have created real momentum with Meaningful Use and other actions related to healthcare. Now, we encourage you to take three steps:

- First, push both providers and vendors even higher with standards related to faster and more robust connectivity. All systems should be able to connect with and accept data from outside systems as if it were their own by using common standards, as we do in the banking industry today.
- Second, it's time to mandate electronic prescribing. This is a patient safety issue. Congress has taken bold steps in this area already in several cases. Let's keep that going.
- Finally, let's continue the initial steps taken to focus on performance metrics and use payment and delivery system reforms to reward physicians who demonstrate positive outcomes for their patients.

In summary, the Final Rule on Meaningful Use will result not only in a higher number of providers participating in the incentive program but more importantly, in higher quality and safer care for patients. We expect most providers to not only meet but exceed the requirements of Meaningful Use . . . what we call Meaningful Value . . . by doing more than the minimum. Our country's physicians, nurses and caregivers are the best in the world. When we provide them with the right information at the right time, they will embrace Electronic Health Records and the information they provide.

We have key clients across the country who are doing just that. The University of South Florida and Wellspan in Pennsylvania are both using EHRs to deliver better diabetes care and better inform patients. Sharp Healthcare in San Diego is approaching 90% electronic orders; Heritage Valley Health System in Pittsburgh is writing 100% electronic prescriptions, and a host of others who are leading the way. Most important, we see leaders like North Shore Long Island Jewish, who is building one of the largest connected healthcare communities in the country and others like Hartford Hospital and University of Massachusetts who are connecting communities for better care.

Your actions have served to both encourage and accelerate all of the activities of these leading organizations and spur other groups to take action. As the technology becomes part of their regular workflow and electronic health records provide critical information, we will see that Meaningful Use is essentially a jumping off point, ultimately resulting in the connected system of health – rather than healthcare – that we are all working towards.

I want to thank you for the opportunity to testify, and I look forward to your questions.

Mr. PALLONE. Thank you, Mr. Tullman.
Dr. Evans.

STATEMENT OF PEGGY C. EVANS

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

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

Our initial experience working with providers strongly indicates that there is a need for EHR technical assistance service through the REC program. For example, there is a community health center in the readiness planning stage of EHR adoption. They received a bid from a commercial, that is a non-REC, consultant for services at $225 an hour for a total bill of $45 million. The cost of a commercial consultant was prohibitively expensive for a community health center and they enrolled in WIREC, thus saving $45,000 for support of patient care and other administrative needs.

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

WIREC's program strategy is threefold. First, we provide on-the-ground health IT coaches that deliver one-on-one customized technical assistance to providers. Second, we establish and maintain network IT communities of practice to share learning. For example, we have implemented an EHR regional group purchase committee with an independent consultant who is facilitating the process and committee members supporting the work. Third, we plan to support peer-to-peer networking activities that will allow participating providers to learn from one another, a very powerful method of communication. Our WIREC staff delivers a suite of services to providers across the three stages of the EHR adoption continuum: selection, go live and optimization. For providers in all stages, we disseminate information about the CMS incentive payments, help providers understand the meaningful-use criteria within a framework for reaching that level of EHR use and provide assistance in workflow evaluation and redesign.

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

Recognizing that providers in our region may have already adopted a multitude of EHR systems as a starting point toward meaningful use, WIREC offers vendor-neutral services and will work with providers regardless of their choice in EHR systems. Among the first several hundred providers who have enrolled with WIREC, they are currently 14 different EHR products already in use which hopefully you can see displayed on the screen. There you go. I won't take the time to read them all but you can see that there is a wide variety of EHRs that we currently support.

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

The REC program focuses on smaller provider offices, community health centers, rural health clinics and other ambulatory practices affiliated with the critical-access hospitals and rural hospitals and providers that primarily treat the underserved and uninsured. As you can see on the display graph, a vast majority of our enrolled providers are from smaller practices. Of the larger practices that we are serving, mostly all are community health centers or rural health clinics.

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

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

In conclusion, Qualis Health's startup experiences show that providers across our region, both urban and rural, are enrolling into the WIREC program and initial feedback from providers shows

that they are finding value in working with the REC program as a supplement to the support that they may receive from their EHR technology vendor. Implementing an EHR system and moving toward meaningful use is a transformation far beyond the technical aspects of implemented a computer system. WIREC looks forward to helping providers embark on that transformation through our vendor-neutral support.

Thank you again for the opportunity to share our experiences.

[The prepared statement of Ms. Evans follows:]

Testimony of Peggy Evans, PhD, CPHIT

Director, The Washington & Idaho Regional Extension Center (WIREC)

Qualis Health, Seattle, Washington

before the House Energy and Commerce Subcommittee on Health

Washington, DC

July 27, 2010

Good afternoon Mr. Chairman and Members of the Subcommittee. Thank you for inviting me here today. I am Peggy Evans, director of WIREC, the Washington & Idaho Regional Extension Center for Health Information Technology. I represent Qualis Health, a private, not-for-profit healthcare consulting and quality improvement organization based in Washington State. Qualis Health's mission is to generate, apply and disseminate knowledge to improve the quality of healthcare delivery and health outcomes. Our programs improve health and healthcare through promoting efficiency and reliability in healthcare; supporting care coordination and improving care transitions; and leveraging health information technology to improve care. Our programs benefit millions of covered lives through our work on federal, state and private contracts and grants, including our role as the Medicare Quality Improvement Organization for the states of Washington and Idaho.

Meaningful use of electronic health records (EHRs) is ultimately about transformation of healthcare. It goes beyond just implementing a computer system and using a digital medical chart, and actually changes the way that providers deliver care to ensure a more reliable healthcare system. I am honored to be here today to speak before you regarding how the WIREC will provide vendor-neutral EHR adoption services to help healthcare providers attain meaningful use and realize the potential for that transformation.

WIREC, The Washington & Idaho Regional Extension Center

In February 2010, Qualis Health was awarded a Regional Extension Center (or "REC") contract from the Office of the National Coordinator. The objective of WIREC is to assist 2,400 priority primary care providers in Washington and Idaho reach meaningful use of their EHR systems by February 2012. We expect that of the 2,400 primary care providers, about 80 percent

will be from the state of Washington, and the other 20 percent will practice in Idaho because of the distribution of population in these two states. The timeframe for this goal is consistent with the duration of the Regional Extension Center contract currently in place between Qualis Health and the Office of the National Coordinator.

Across the country, the organizational model of Regional Extension Centers varies from center to center. Some RECs have structured their centers such that the prime contract holder serves as a hub of education and information, but partner organizations do the actual delivery of EHR technical services to providers in the field. On the other side of the spectrum, some RECs have adopted the model of providing most of the hands-on direct assistance to providers themselves, but engage partners for broad education and provider outreach support. WIREC is a hybrid of the two models just described. Qualis Heath has the depth of knowledge and staffing to provide technical assistance to healthcare providers ourselves, and we have also partnered with five premier health IT adoption entities in Washington State and Idaho. In Washington State, these partners are: Community Choice Healthcare Network, Inland Northwest Health Services, and PTSO of Washington. In Idaho, these partners are: Idaho Health Data Exchange, and the North Idaho Health Network.

WIREC's program strategy is three-fold. First, we provide on-the-ground health IT coaches that deliver one-on-one, customized technical assistance to providers. The customization recognizes that providers are in different stages of EHR adoption and often have specific needs that we must address to best assist them to successfully adopt their EHR systems. Second, WIREC is establishing and maintaining networked IT communities of practice to share learning, and has implemented an EHR Regional Group Purchase Committee, with an independent consultant who is facilitating the process and the committee members supporting the work.

Third, we plan to support peer-to-peer networking activities that will allow participating providers to learn from one another, a powerful method of communicating information.

Providers often start their EHR adoption believing that once the technology has been installed, they are at the end of their EHR implementation journey. In fact, once implementation has occurred, the journey has just begun. Technology is a great tool when it works well, but no matter how well it works, it is just a tool. Training people to utilize their technology is an essential component of successful EHR adoption. WIREC helps participating practices bring together their optimized technology with staff trained on how to use that technology through practice redesign and role clarity so that the two pieces – people and technology - can work together in concert to deliver more reliable and efficient patient care.

Currently, WIREC's Health IT Consultant staff includes 11 seasoned professionals with expertise in a variety of health IT topics. While all 11 staff members demonstrate skills in EHR selection, implementation, and optimization, some have clinical backgrounds, others have strong IT skill sets, and yet others possess health IT analytic backgrounds. The WIREC consultants have had experience with multiple EHR vendor systems and in-depth knowledge of various healthcare sectors, including Community Health Centers, HMOs, private practice, and hospitals. All of our consultants have an intimate understanding of the challenges that providers are facing with health IT adoption, as well as providing healthcare to patients.

Our WIREC staff delivers a suite of services to providers. We consider ourselves as coaches that can guide providers through the EHR adoption continuum. For providers at the selection phase, we offer readiness planning for EHR selection, as well as support through vendor selection and negotiation. Providers that are preparing for a "go-live" can utilize our services for EHR go-live planning, data migration planning, and system stabilization. We assist those in the EHR optimization stage with quality improvement reporting, and of course,

meaningfully using their EHR systems. For providers in all stages, WIREC disseminates information about the CMS incentive payments, helps providers understand the meaningful use criteria and determining a framework for reaching that level of EHR use, and provides assistance in workflow evaluation and redesign. The importance of workflow redesign cannot be stressed enough. Many providers are under the assumption that they will transition from paper to EHRs, but continue to use the same workflow processes that supported their paper-based records. Health IT professionals and researchers have shown time and time again that successful EHR implementation and utilization is strongly dependent on consideration of workflow changes. WIREC helps providers understand this approach and offers different models for workflow training. For example, in addition to providing one-on-one workflow redesign assistance, we are also in the midst of planning a process redesign workshop for multiple geographic communities.

Recognizing that providers in our region may have already adopted a multitude of EHR systems as a starting point toward meaningful use, WIREC offers vendor-neutral services and will work with providers regardless of their choice in EHR systems. Among the first several hundred providers who have enrolled with WIREC, there are currently 14 different EHR products already in-use, including:

- Allscripts Professional
- Allscripts MyWay
- GE Centricity
- DocLinks
- E-Clinical Works
- EHS Care Revolution
- E-MDS
- Encite
- Greenway
- Office Ally
- McKesson
- NetPractice
- NextGen

- SOAPware

(See Figure 1.) We anticipate supporting additional products as enrollment into the WIREC program progresses, as WIREC offers vendor-neutral consultation and support.

The target population for the REC program focuses on four populations: 1) Smaller provider offices that have 10 and fewer providers, 2) Community Health Centers, 3) Rural Health Clinics, and those affiliated with the Critical Access Hospitals, and 4) Providers that primarily treat the underserved and uninsured. Our initial experience working with these types of providers indicates strongly that there is a need for EHR technical assistance services through the REC program. For example, we are working with a Community Health Center in Idaho that is in the readiness planning stage of EHR adoption. To their credit, this CHC had already started to think about workflow redesign and the impact of a new EHR system to their current processes. In discussing their needs with a commercial (non-REC) consultant that offered to help them, they were quoted an hourly rate of $225 per hour, and a proposal for 200 hours with a total bill of $45,000 dollars. The cost of commercial consultant services was prohibitively expensive for a community health center, and the CHC in this story enrolled as a participant in WIREC.

Another independent, small private practice was working with a commercial EHR vendor and getting ready for go-live in 6 weeks when they enrolled into the WIREC program. At our first site visit, we learned that the practice did not know about workflow redesign nor had they considered designating a clinical champion or project manager for their EHR implementation. While EHR vendors help providers with a bulk of their implementation and technology needs, providers often need to understand that there are tasks on their end that should be completed in order to help them help themselves, which is where WIREC steps in.

Upon a provider's enrollment into the WIREC program, we ask providers to complete a needs assessment. We then designate a WIREC Health IT Consultant to guide the provider to the best and safest approach for EHR adoption and reaching meaningful use, dependant on their responses to the needs assessment and their status on the EHR adoption continuum. The WIREC consultant will also help determine if the provider has the appropriate hardware and make recommendations for change if needed. For providers in all stages of EHR adoption, WIREC consultants will give them the information required to allow providers to evaluate which CMS incentives may be the best for them, and help providers understand the evolving nature of meaningful use. Our position as the REC also allows us to consistently scan the national, regional, and local environment for information and provide real-time course corrections for providers when obstacles are present or information has changed.

Because one of WIREC's major objectives is to assist providers in meaningfully using their EHR systems, our consultants are also prepared to do on-site meaningful use readiness assessments. This includes identifying the gaps between where the provider is now and where s/he needs to be in order to reach meaningful use, and then laying out a customized path for how to achieve meaningful use. We have received feedback from many providers that the meaningful use criteria just seem like a mass of expectations and they do not know how to take even the first steps toward meaningful use. WIREC staff provides a framework for understanding the meaningful use criteria that is more readily digestible by providers and their staff and then suggest "do-able" chunks that providers can tackle without being overwhelmed.

WIREC Program Enrollment and Current Project Status

The WIREC contract was awarded in early February of this year. To date, in our first few months we have successfully enrolled practices that represent about 500 primary care providers.

(See Figure 2.) Among our initial enrollees, practice site locations are spread across the two-state region, including both urban and rural sites. The type of the WIREC enrolled practices are aligned with the mission of the REC program to service smaller provider offices, Community Health Centers, Rural Health Clinics, and those that primarily treat the underserved and uninsured. (See Figure 3.) Of the 500 providers enrolled into WIREC, a vast majority are from smaller provider offices. Of the larger practices that we are serving, mostly all are Community Health Centers or Rural Health Clinics.

Our recruitment effort continues as we move toward our goal of assisting over 2,000 providers reach meaningful use. WIREC recruitment has benefited substantially from outreach assistance through partners and stakeholders across the region, particularly state government programs and professional associations that supported WIREC's original proposal for ONC funding. Tactically, our WIREC team also pursues recruitment through direct contact with providers, visibility at pertinent events in the region, and recruitment information deployed via the WIREC website.

Following the first few months of initial enrollment efforts, the WIREC IT consulting team has now begun providing direct assistance in the field to our participating practices. Following the initial site visit to the medical practice, we send out a customer satisfaction survey and collect anonymous feedback for use in our on-going internal quality control efforts. (See Figure 4.) Among our practice sites thus far, 100% of providers have reported satisfaction with WIREC services, with 70% indicating that they are "extremely satisfied." The number of practices surveyed thus far is small, but the results are encouraging.

We have also provided group learning opportunities in addition to on-site technical assistance. Our educational webinar series for providers has been very well received, with evaluation responses showing consistent ratings around 90% of respondents agreeing that each

of the sessions has been of value to them. (See Figure 5.) This educational webinar series is now offered monthly, with every other month focusing broadly on strategies for attaining meaningful use and the other months focusing in-depth on a technical topic related to EHR adoption and meaningful use.

Collaboration and Coordination with other HITECH/ARRA Funded Entities

As a REC awardee operating with ONC funding, WIREC coordinates with other entities that have also received HITECH/ARRA funds through bi-weekly meetings and ad-hoc committees. In particular, we collaborate on ensuring that messages to providers about the CMS incentive funding, meaningful use, and the different HITECH projects are standard and consistent. Recently, WIREC worked with each state's Medicaid program to develop a fact sheet for providers about the incentive funding, and in Washington State, coordinated with the Statewide Health Information Exchange awardee, the Beacon grant awardee, the Community College Workforce Development awardee, as well as the state's Medicaid program to develop common communication messages related to meaningful use. Inland Northwest Health Services, the Beacon grant awardee, is also a WIREC technical assistance partner.

In addition, WIREC has an active collaboration on health IT workforce development with Bellevue College, the lead on the Region A 10-state community college consortium. Through Bellevue College, we currently have four interns working with WIREC, learning about meaningful use and workflow redesign, and benefiting from direct observation during site visits. We expect to continue our collaboration with Bellevue College through the development of an employment networking program, and work with additional interns in support of the College's health IT course offerings.

We share a vision of successfully achieving meaningful use of health IT across our region with a host of other partners and stakeholders. Many of our partners have significantly supported our initial recruitment efforts and promotion of educational programs through their newsletters, email blasts, in-person presentations and websites. Our partners include Washington and Idaho's state medical and hospital associations, area health education centers, independent practice associations, health center-controlled networks (or HCCNs), state universities, state departments of health, and others.

Summary

In conclusion, Qualis Health is honored to be among the 60 entities implementing the REC program. Our start-up experience shows that providers across our region, both urban and rural, are enrolling into the WIREC program, and initial feedback from providers shows that they are finding value in working with the REC as a supplement to the support they may receive from their EHR technology vendor. Each provides different but complementary services.

Implementing an EHR system and moving toward meaningful use is a transformation, far beyond the technical aspects of implementing a computer system. With our vendor-neutral support, WIREC is helping ONC's priority providers embark on that transformation.

Thank you again for the opportunity to share our experience.

Figure 1: WIREC providers' diverse EHR products

- Allscripts Professional
- Allscripts MyWay
- GE Centricity
- DocLinks
- E-Clinical Works
- EHS Care Revolution
- E-MDS
- -Encite
- -Greenway
- -Office Ally
- -McKesson
- -NetPractice
- -NextGen
- -SOAPware

Figure 2: WIREC participating clinic sites, July 2010

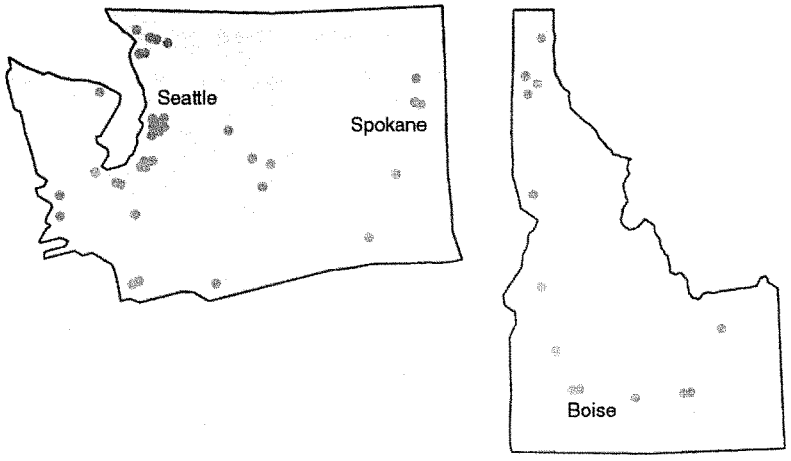


Figure 3: Number of providers per enrolled WIREC practice

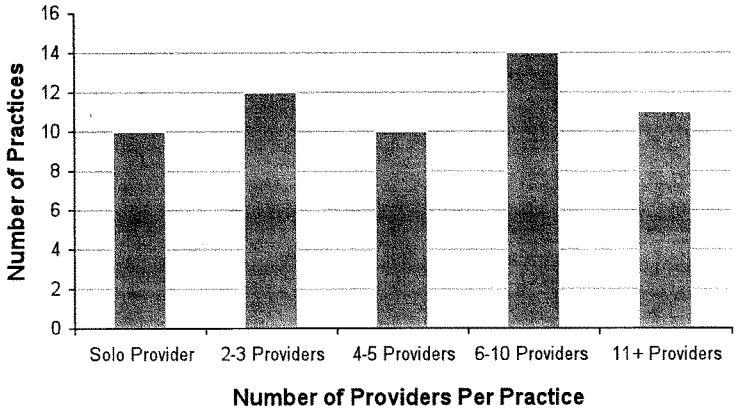
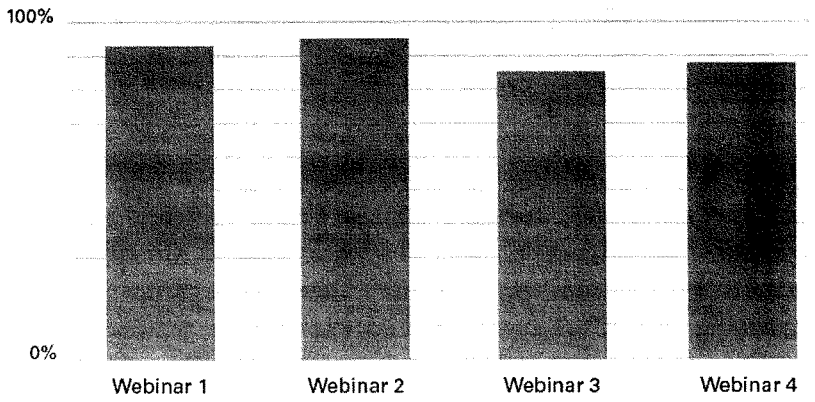


Figure 4: Initial provider satisfaction with WIREC services, July 2010

WIREC consultant support was valuable	100%
WIREC consultant is knowledgeable	100%
WIREC consultant doing a good job assisting my organization with EHR adoption, implementation, utilization	100%
Satisfied with WIREC services	100%

Figure 5: Providers who agreed that WIREC educational series provided value



Mr. PALLONE. Thank you, Dr. Evans.

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

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

Dr. VOZOS. Our health system, as you know, was developed really back in 2004, April 2004, and the reason we put it together was that though we had a lot of clinics, you know, we saw that the long-term evolution of those clinics was going to be a continuing loss of money and plus we had declining of services to the community in our area there. So converting that to a federally qualified health center and also with the reimbursement that was available to a federally qualified health center, you know, really kind of saved it, not only saved it, actually grew it to where it is probably one of the premier health providers in the area. In fact, it provides pretty good competition to private practitioners.

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

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

Mr. PALLONE. How does the HIT fit in with——

Dr. VOZOS. What we did was initially we connected them. It is a one-way connection right now from the FQHC into our hospital, meaning that they can access all the record of the patients that are in our hospital that they see in the clinic, and as you could imagine, most of the patients in that clinic when they do need to come to the hospital, they use Monmouth Medical Center or the Monmouth emergency room. So the physicians of the FQHC have direct access through the Internet into our——

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

Dr. VOZOS. Well, that is our other pilot program where, you know, under a grant we——

Mr. PALLONE. This is the demonstration program?

Dr. VOZOS. Right.

Mr. PALLONE. That was my second question.

Dr. VOZOS. Yes, and that program, what the pilot was to take all the patients who really were using our emergency room as their medical home, so to speak, identified those that really needed to have a primary care provider and arranged for them to be followed up in our federally qualified center. We thought initially we could easily make that happen once but we were kind of curious as to what the true conversion was going to be where they were not going to use the FQHC as their private, you know, physician office. There has been a 70 percent conversion. It has been really a tremendous success, and what it has done is, it has decompressed the emergency room, improved the throughput for the emergency room and really unclogged our emergency room and created a whole—a much better atmosphere even in our emergency room.

Mr. PALLONE. But it also made it possible for the people that have regular care so they didn't——

Dr. VOZOS. Well, they now have——

Mr. PALLONE [continuing]. End up just using the emergency room.

Dr. VOZOS [continuing]. A regular physician in the FQHC.

Mr. PALLONE. Now, is there also a Medicare demonstration program that looked at whether gain sharing between hospitals and physicians can reduce cost?

Dr. VOZOS. Right.

Mr. PALLONE. And then there was an electronic health records component of that too?

Dr. VOZOS. Yes, there is. We are part of a Medicare demonstration project, which is 12 hospitals in New Jersey, where we put together a set of criteria with the coordination of the New Jersey Hospital Association, a set of criteria to measure quality care, and if in the performance of these measures there was a savings of money, you know, the federal government has kind of relaxed itself a little bit and allowed us to share in those cost savings. So we have recently gone through the first phase of that where there was not only the signing up of physicians but we completed the first 6 months of measuring data, and what we are looking at right now is length of stay, complications, mortality rates and readmission rates, and there was—we actually issued the first set of checks and now we are going through the second phase of additional enrollment because initially not everybody wanted to enroll. They either didn't trust the project, they didn't want to have their name in some file that the federal government could be steering. There is all kind of reasons why doctors wouldn't sign up. But after the first phase of this, not we have had about three times the number of physicians signing up. So we are going to be well over 200,000 physicians signed up for this, and it has actually produced savings.

Mr. PALLONE. All right. Thanks.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I have been writing and scratching notes all over the place, so this may get really disjointed, which would be very similar to most of my questions that I ask. But it has been very educational. I am a very outspoken crit-

ic of the stimulus bill but obviously we can se some future benefits down the line in this provision.

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

Dr. VOZOS. I would say at Monmouth the upgrade to the Cerner Millennium——

Mr. SHIMKUS. Let us talk about stimulus dollars.

Dr. VOZOS. Right. I mean, we need to do that in order to be able to qualify at any point for the stimulus dollars.

Mr. SHIMKUS. So your upgrade was, but your original deployment was not?

Dr. VOZOS. No, original deployment was Cerner.

Mr. SHIMKUS. And Dr. Winkleman, I know that none of yours was done based upon—your practice made the decision on their own and incurred the capital expense and assumed the risk.

Dr. WINKLEMAN. Yes. I mean, our practice made the decision to move forward with this several years ago before there was discussion of money available.

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

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

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

Mr. SHIMKUS. And you would put those above HIT?

Mr. STARNES. If I have a person come into the emergency room and need a CAT scan, I need a reliable CAT scan machine in order to provide that service, so I have got to put that just ahead of EHR at this point.

Mr. SHIMKUS. Right, and that does segue into kind of Dr. Evans' point because I think your testimony mentioned about how you can be in essence a low-cost consultant for small rural hospitals and practitioners but you are paid on the government dole, you are not a private consultant that is for profit, paying taxes, paying for the office space, paying properly taxes and other issues because you are

part of this government payout that we are doing, but I am not going to argue with the help but there is probably some computer consultants who now, you are the lowest bidder on providing, you know, consulting services and so they are probably going to Mr. Tullman trying to find a job over in his sector.

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

Dr. VOZOS. If that it all that occurs, yes.

Mr. SHIMKUS. You would be?

Dr. VOZOS. Of course I would be.

Mr. SHIMKUS. You are a major——

Dr. VOZOS. I am a major teaching hospital but I am going to rely on those 32 million or the 1.3 million people in New Jersey who now have insurance to cover that reduction in Medicare reimbursement. I have to rely on that.

Mr. SHIMKUS. Well, we can talk about that later on. And Mr. Starnes, kind of the same question. I am shocked. I thought you would be saying I can survive it because we are big.

Now Mr. Starnes.

Mr. STARNES. Under the critical-access hospital designation, then hopefully we will be fine, but it is not going to be easy for sure. We will have to be lean from——

Mr. SHIMKUS. You are already lean. You already can't provide needed capital equipment to your hospital.

Mr. STARNES. Right. Yes.

Mr. SHIMKUS. Mr. Chairman, my time is expired and I will yield back.

Mr. PALLONE. Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman.

My first question, and it may have been covered in the absence with the other witnesses and it would have been appropriate for them, but it is a situation that in San Antonio the hospitals have made me aware of, and I want to make sure that I frame the question, that is that the Medicare incentives to grantees would be based on a CMS provider number if you have multiple campuses, so if there is anyone on the panel can explain the consequences of having one Medicare number but having more than one campus as far as the incentives and how that would be paid. I don't know if Doctor, is it Vozos?

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

Mr. GONZALEZ. Anyone else have an opinion on the problems that that may present?

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

Mr. GONZALEZ. I understand a rural setting is totally different from what I have described, and Mister—let us see. Where is—well, it is Dr. Winkleman. I apologize. Mr. Shimkus has touched on the cost and how we would go about assisting. We know about the stimulus money but of course that is finite and such, but prospectively, as a physician, how is someone's practice going to afford the technology and the training? We introduced a bill a couple of years ago and it was a bipartisan bill. It was never passed, but we had everything in there. But I want your opinion, anyone on this panel that could give me an opinion as to the best way to assist the physicians to make that transition. We could have grants, a combination of grants. We could have low-interest loans, guaranteed, or tax credits or tax incentives. Is there any way that we should rank those or just have them all available? Anybody?

Dr. WINKLEMAN. Well, I think that having money and grants available to help physicians use electronic records is a positive thing but ultimately I think even better than that is that physicians begin to get paid for doing a good job and that as we start to—that our practice gets transformed by things like electronic health records, that industry will be motivated to make a product that works well, they will be motivated to make a product that produces better care, I am going to be motivated to use that product to provide better care, not just intuitively for my patients but because I am rewarded for it. So I think creating an environment where we are encouraged to use things like this to improve the quality helps make that transition make financial sense to a doctor because when you look at it on paper, sometimes it is a tough sell. There is a lot of upfront capital cost. There is initial reductions in productivity. On the long term, there are gains. I think a lot of practices become more efficient. They certainly do a better job of billing and coding to get paid for what they actually do. So I think one of the ways to do it is to make them make financial sense, and part of that would involve creating a situation where our reimbursement is tied to us doing a good job, not just seeing a volume of patients.

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

Mr. PALLONE. Thank you. I am going to have a second round for anyone who would like to participate, and I will start with myself.

I am going to go back to Dr. Vozos, but I guess any of you could answer it. When I was—I mean, we asked many of you to come here today because we knew that you were being innovative with

HIT, you know, before we passed the Recovery Act and we put in this legislation that we have been discussing. I mean, the idea at least in my mind was to hear from those who have sort of been the precursors and did this before there was any money from the federal government through the Recovery Act. But I would like to know, because I know when I went to Monmouth Medical Center that even though we discussed all the things that we are doing, you also discussed with me what you could do if you were able to tap the funds under this legislation. So maybe you should talk to me a little bit about where you would go from here, assuming you participated in this program.

Dr. VOZOS. I mean, we are on the road and we are making a lot of moves but we are far from there, and it is going to be a tough journey and an expensive one, so really funding for us it going to be a big issue going forward. You know, for Monmouth Medical Center the full-blown HIT system is going to be about $19 million over some period of time, and when I listened to Mr. Starnes talk, I said I want to go find out where you are buying that one, that $750,000 one. So it is a $19 million project for our system. It is just shy of $100 million. So as you can imagine, there needs to be all type of incentives to be able to spend that kind of money. Now, there is the return on investment so I would say right now, you know, we are moving forward on a regular basis. We still have to install more modules into our system to be able to get to the level where we are fully operable to even qualify for the stimulus money and that is what we are doing right now. So it will change the practice at the hospital for sure. I mean, it will change even how testing is done and what the residents are learning and the efficiency of the hospital but we have a road to go, but there is a bit team working on it and continues to work on it. And our big thing is linking the physicians and private practices and private offices and having a two-way exchange of information. We want to be able for them to populate the record in the hospital from what they're doing in the office but at the same time what is happening with their patients in the office should be able to go the opposite direction back into their office records too, so that is why we view as very important to have very compatible EMRs in the physician office and at the hospital with the appropriate interfaces set up, and we are putting a lot of effort into doing that.

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

Mr. TULLMAN. I think it is a good question. What we have seen, and you recognized that this panel includes a number of innovators who have taken those steps, and I commend Dr. Winkleman and the other physicians and members of the panel for taking those first steps, but in technology adoption generally you get the first 20 percent are early adopters. The next 70 percent are where the real dollars and the benefits are and they take longer, and so the

incentive program that you have put into place will help us get the next 70 percent and drive that throughout the rest of the market. From our perspective, we believe we are ready. We are investing heavily in making sure that the systems are easier to use, more easily deployed, and again produce the kind of measurable results that we need in health care, and I think the RECs, the regional extension centers, the other programs that have been designed are going to help us move that along. There are tremendous employment opportunities. There is tremendous work to do, and that is not just from the vendors, that is from actually the medical centers across the country.

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

Mr. PALLONE. All right. Thank you, Mr. Tullman.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

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

Mr. STARNES. It is Northern Illinois University.

Mr. SHIMKUS. And that is located where? DeKalb?

Mr. STARNES. Yes.

Mr. SHIMKUS. And how far is DeKalb from Vandalia?

Mr. STARNES. I couldn't tell you. Somebody else?

Mr. SHIMKUS. Four and a half, five hours.

Mr. STARNES. OK.

Mr. SHIMKUS. I know Idaho-Washington is a big area too, so, I mean, it is just a point I wanted to raise.

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

Mr. TULLMAN. We really—I will take the first shot at that. We believe and what we are seeing is accelerated adoption across the board, so we know that at least until the stimulus package, the larger organizations were in fact advantages because they had CIOs, they had a capital budget and the like. What the stimulus program does it open it up so smaller physician groups and offices and independent physicians can do that. That is number one. Number two, a lot of the larger organizations, for example, I mentioned North Shore Long Island Jewish, what they have done is, they not only bought licenses for their 1,200 employed physicians but they have actually extended that offer to 7,000 affiliated physicians in the community to help connect them up and bring those benefits.

The last point is that many of the vendors have come out with innovative programs like a financing program with no payments for 6 months to help bridge the gap until smaller providers actually get the stimulus funding. So I think you are seeing a lot of innovation.

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

I got a chance to visit with Dr. Winkleman earlier today, and he brought up this issue that even though he is—and I have to do this before I do that. I am sorry. Two letters, I ask for unanimous consent, and one is a compelling argument of a community of 15,000—Mr. Starnes would know— Washington County Hospital, Nancy Newby, president and CEO, a population of 15,000. They are on HIT already and did the risk, did the same thing. So there are folks who realize the importance of this and did it previous to the government intervening.

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

Dr. WINKLEMAN. We will have a very hard time achieving the standard under the—well, let me back up. We will be very close under the Medicaid, the arm of being 30 percent. Our problem under the Medicare arm is that since our reimbursement comes via the rural health clinic system and not directly from Medicare. Our charges to the Medicare fee schedule are very limited. The only thing we bill to Medicare fee schedule under fee-for-service are some ancillary things. So we really don't have a Medicare option despite the fact that we see a good percentage of Medicare patients. You know, we really are limited to the Medicaid option. And so for some of my partners—it would be different for me, I do family medicine where a see a good portion of children and a lot of them are Medicaid, but some of my partners that do primarily internal medicine, primary care and see mostly adults, a lot of those patients are Medicare and then they could be sort of left out in the cold. Seeing a large number of Medicare patients, having adopted EHR, using them meaningfully, and yet we don't really have the Medicare charges per se technically that qualifies under the incentive.

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

Ms. EVANS. Yes, and actually we have heard the same concern from many of the rural health clinic providers that we have been talking to that they are shut out because they may not—they basically bill via a bundled mechanism rather than the provider fee

schedule so that leaves them out of Medicare, and then they don't see the 30 percent patient panel required for Medicaid or 20 percent of their pediatricians. So they are really very much interested in how CMS is going to address the fact that there may be no incentive payments coming to them.

Mr. SHIMKUS. Well, hopefully CMS is paying rapt attention to this hearing and that is part of the record.

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

Mr. PALLONE. Thank you. Mr. Shimkus has asked unanimous consent to enter these two documents into the record. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Mr. Gonzalez.

Mr. GONZALEZ. Thank you, Mr. Chairman.

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

Mr. SHIMKUS. I usually don't.

Mr. GONZALEZ. That is an understatement. But anyway, this is Hilda Gorito of Kaiser Permanente: "If you give a lumberjack who has been using an ax his whole life a chainsaw and he starts hacking at a tree with it, it is not going to help him at all. It is what you do with the technology that makes the difference." So you go there, and so now the physician who used to be a lumberjack now has the chainsaw, and you are going to teach him basically how to use that effectively about the technology. When you go on site, are you discovering that many times—I don't know how to put this—they have overpurchased? One size doesn't fit all, and my experience has been with my friends who are physicians and a couple of friends who actually sell the systems that a lot of physicians really are not—because you are coming after the fact, that prior to the purchase of what is a very expensive investment that it is not done many times with the knowledge. And Mr. Tullman, I want you to chime in as soon as Ms. Evans finishes. Where does a physician or a small practice get the direction and the advice to purchase only that which they really need and to make an investment and not realize the return that they could?

Ms. EVANS. Well, my experience in doing some of the consulting out in the field is that many times providers purchase something and then underutilize the system for a variety of reasons. I can't really speak to whether they have overpurchased, but what I have seen is that there are many functions and features that are available to them, particularly for reaching meaningful use, that they haven't even necessarily looked at or they don't know exist. And so we go into the practice to educate them about some of the availability of the features and functionality as well as determine the

workflow by which they might be able to use the system is a more effective manner.

Mr. GONZALEZ. Your thoughts, Mr. Tullman?

Mr. TULLMAN. Yes, I think I would concur, and we think the largest problem, most significant problem is underutilization, and that would be true in most pieces of software that people buy. They tend to use them not at the maximum but the minimum, so we think the RECs are a good idea. We also are seeing more and more physicians get counseling from a variety of ratings services so as a vendor we are evaluated by a number of different organizations and of course CCHIT, there are minimum requirements, so there used to be about 300 different electronic health record providers. Last year under CCHIT to meet the minimum standards, that 300, only 70 qualified as meeting the minimum requirements. Those requirements are now even greater and will continue to get greater, and we think that is a good thing. We think that it improves the value of the products.

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

Mr. GONZALEZ. Last question. I have a minute. Ms. Bechtel, you represent the consumer and such, and I am one of those that just believe that a patient goes in there believing that the doctor is up to date on the latest literature, continuing education, has the best equipment and so on. Do you believe that HIT should be part of that equation, that each patient should expect that that particular physician have that electronic medical records and the efficiency, effectiveness and cost savings that it should bring?

Ms. EVANS. I do, and I think it is interesting because there are a number of consumers who see technology in every other sector in this country and assume that their physicians have it as well, but then they experience the acute challenge of trying to communicate with the care team, trying to coordinate their own health care, understanding that doctors just aren't talking to each other fully and in the way they could be without interoperable health IT and so we have done actually a fair amount of research with consumers directly to understand what do they think about information technology and the reasons that it appeals to them are exactly those but they get that it will begin to reduce the burden that they face, particularly around care coordination. So we would be delighted to start to see consumers asking their physicians are you a meaningful user of information technology, do you have an electronic health record. I know that when I chose my own doctor recently, it took me several months to find out that has an electronic health record, and I did, but to the point of this hearing, the practice actually doesn't use it in a meaningful way whatsoever. They really just actually automated paper. So I think the conversation has to start with, do you have an electronic health record, but it can't end there. It has to be, how are you giving me access to my health information, how are you sending me reminders, how are you summarizing my care for me and other benefits of technology.

Mr. GONZALEZ. Well, I thank all of you for your testimony. I yield back, Mr. Chairman.

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

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

Without objection, this meeting of the subcommittee is adjourned.

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

[Material submitted for inclusion in the record follows:]

Statement of Representative Henry A. Waxman
Chairman, Committee on Energy and Commerce
Subcommittee on Health Hearing
Implementation of the Health Information Technology for Economic and Clinical Health Act of 2009
July 27, 2010

I thank Mr. Pallone for holding a hearing on this timely topic. In February of 2009, Congress passed the Health Information Technology for Economic and Clinical Health Act or HITECH Act. The HITECH Act included many provisions from a bipartisan health IT bill that passed out of this committee in the previous Congress. This hearing is an important step in ensuring that members of this committee remain focused on how the law is unfolding on the ground with providers, patients, and others.

The HITECH Act was a historic investment in health IT, patient safety, and quality of patient care. The goal of transforming the health delivery system to include electronic health records for everyone was ambitious yet long overdue. Electronic health records will put providers in a position to:

- First, better understand the demographics of their patient population and the most prevalent illness their patients are confronting,

- Second, work with others in their community to ensure efficient handoff of critical information between providers so they can make the best clinical decisions

- Third, get the benefits of clinical decision support to ensure that the most effective care is delivered safely after automatic checks for drug allergies and interactions.

In addition, through patient portals and access to their electronic records, patients can become more engaged in their own health care and more aware of preventive services that can help them to stay healthy.

Recently the office of the National Coordinator for Health IT and the Centers for Medicare and Medicaid Services put out final rules on standards for the meaningful use of a certified electronic health record. These are the rules that lay the foundation for what an electronic health record needs to include, what it needs to be capable of. It also is the basis for what types of activity a doctor or hospital need to engage in and what metrics each need to track to show meaningful use of that electronic health record in order to secure incentive payments through Medicare and Medicaid.

There were significant changes in this rule from the proposed rule months ago that were responsive to the many comments they received. Some will say the standards are too stringent and unachievable, others will say they don't go far enough and will not result in the types of electronic exchange of information that results in better care coordination and patient safety changes we had all hoped. I think that tells us that the administration has attempted to find a compromise between the goals and concerns of different sides. I think it also means we will have room to strengthen the requirements over time as we gain confidence in the ability of the systems and providers to achieve higher goals.

I am pleased to welcome Dr. Blumenthal and Mr. Trenkle to walk us through the many initiatives and detailed work they have engaged in to make real Congress' goals for this legislation. In particular I am glad to hear about the investments that the office of the national coordinator is making towards this larger effort. Much more than just putting a computer on every doctor's desk, this legislation aims to have actual electronic exchange and use of information that can transform and modernize the delivery of health care. This requires a national set of standards for electronic health information as well as regional health information exchanges to support the adoption of best practices being developed and disseminated through the beacon community grants.

In addition, I want to thank the stakeholders for their input and perspective from the field. I look forward to continued oversight of these efforts as implementation continues.

The Academy Advisors

Statement for the Record

Submitted by
The Academy Advisors, an affiliate of The Health Management Academy

House Committee on Energy and Commerce
Subcommittee Hearing on Health Information Technology
July 27, 2010

Chairman Pallone, Ranking Member Shimkus and members of the Subcommittee on Health, The Academy Advisors is pleased to submit the following statement for the subcommittee hearing on *Health Information Technology*. The Academy Advisors is the policy development affiliate of The Health Management Academy, an educational services company providing best practices information and benchmarking data to senior executives of 90 leading health systems with 1,400 hospitals. The Academy Advisors works with a nationally representative group of leading health systems comprising 126 hospitals in 23 states that care for nearly 19 million patients annually.

The leading multi-hospital systems believe in the value of health information technology and they have made a substantial financial and organizational commitment to implement advanced computer technology in support of delivering high quality, cost effective healthcare.

Congressional Intent – All Hospitals Eligible for National Stimulus Program
We applaud Congress on passage of the HITECH provisions of the American Recovery and Reinvestment Act of 2009 ("ARRA"). These provisions will promote the health policy of delivering high quality and cost effective care through broader use of electronic health technology ("EHR") by hospitals and physicians. The legislation specified that all subsection d hospitals meeting meaningful use standards would be eligible for the HITECH national program. Hospitals and physicians believe that patients come first and Congress was interested in spreading the benefits of EHRs to as many people as possible.

Multi-campus Issue – CMS has Chosen not to Fulfill Congressional Intent
The Centers for Medicare & Medicaid Services (CMS) *proposed rule* published January 13, 2010, excluded subsection d hospitals that do not hold a unique CMS Certification Number, or provider number. Multi-hospital systems, however, often have a single provider number for reasons of history, administrative convenience or, in certain cases, state encouragement. More than 300 members of Congress, including committee Chairmen and Ranking Members, wrote or contacted the agency expressing their intent that every hospital be eligible for the HITECH program.

In the *final rule*, published July 13, 2010, rather than follow Congressional intent by giving the language a simple literal interpretation, CMS has chosen to ignore Congressional intent and provide incentive payments only to hospitals that hold a provider number. Consequently, hospitals without a unique provider number – because they share a provider number with another hospital – will not have the opportunity to qualify for the incentive payments which would be used by the hospitals to employ EHRs to reach more patients.

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By choosing to allow some hospitals to qualify for Medicare and Medicaid incentive payments and others not, CMS is unduly excluding certain hospitals, based only on whether the hospital holds a provider number, a simple technicality that has no bearing on the willingness or interest of the hospital to accelerate adoption of EHRs.

Multi-hospital systems where each of its hospitals hold a provider number will receive the $2 million base payment in addition to $200 per patient discharge for the 1,150th – 23,000th discharges. Those multi-hospital systems where each hospital does not hold its own provider number will be significantly disadvantaged because they will not qualify for incentive payments even though all hospitals face similar design, development, implementation and workforce training costs for implementation of EHRs.

Based on a survey conducted by The Academy Advisors and subsequent projections our research shows that 277 hospitals throughout the nation do not hold a provider number representing a fiscal impact of $882 million.

The Precedent Exists for all Hospitals to be Eligible

Given the history of the "remote locations" regulation that is part of the regulations for creating the outpatient prospective payment system (OPPS) as required by the Balanced Budget Act of 1997, it is clear that CMS has the discretion to treat each hospital within a multi-hospital system as a separate "remote location" for the purposes of providing ARRA HIT incentive payments. CMS has previously identified remote location hospitals in a multi-hospital system in order to determine a wage index appropriate for each unique hospital's location.

ARRA HIT Incentive Payments have Limited Duration

CMS has expressed concern that exercising its discretion to treat each campus separately may set a precedent for payments with a different purpose, such as the DSH payments. The ARRA HIT incentives are limited in scope and duration and "jump start" the adoption of technology rather than serve as a payment subsidy, e.g., DSH.

Legislation is Required to Fulfill Congressional Intent

Even after hundreds of provider comments and clearly evidenced Congressional intent, CMS issued the final rule regarding incentive payments for EHRs and failed to revise its proposed identification of a hospital by its Medicare provider number. In order to fulfill Congressional intent to extend EHRs to as many people as possible, each hospital should have the opportunity to receive incentive payments if they meet meaningful use requirements. The rationale exists, based on remote location regulations, to provide CMS with the necessary authority to make incentive payments to all hospitals meeting meaningful use requirements. Congress should enact legislation to require that CMS fulfill the original Congressional intent embodied in ARRA.

The Academy Advisors appreciates the opportunity to submit this statement for the record and we, along with the leading health systems involved in The Academy Advisors, are eager to work with the subcommittee on a legislative solution to the multi-campus issue.

PREMIER

Statement for the Record

Submitted by

The Premier healthcare alliance

House Committee on Energy and Commerce
Subcommittee on Health

Implementation of the Health Information Technology for Economic and Clinical Health Act of 2009

July 27, 2010

Chairman Pallone, Ranking Member Shimkus and members of the Subcommittee on Health, the Premier healthcare alliance is pleased to submit the following statement for the record for the hearing "*Implementation of the Health Information Technology for Economic and Clinical Health Act of 2009*." Premier is a performance improvement alliance of more than 2,300 community-based hospitals and 68,000 other healthcare sites using the power of collaboration to lead the transformation to high quality, cost-effective healthcare. Health information technology (HIT) is an important tool with vast potential to help achieve this transformation. While Premier and its member hospitals are still reviewing the final meaningful use regulation, we would like to take this opportunity to make the subcommittee members aware of a key issue that disadvantages hospitals with multiple inpatient facilities operating under one provider number that will require an immediate legislative solution, which is described at the end of this statement.

Premier is committed to facilitating rapid implementation of electronic health record ("EHR") technology by all Premier alliance members. We believe these technologies will greatly help improve quality and efficiency, and lead to improvements in community health. To facilitate the transformative "wiring" of the healthcare system, Premier formed an HIT Collaborative to provide technical assistance to Premier alliance members who are working to implement EHRs and meet the requirements of the HITECH Act. To speed our members on their journey to achieve meaningful use (MU) of EHRs, the collaborative developed the EHR MU Implementation Best Practices Library. Organized by the MU criteria matrix, the library offers a checklist of best implementation practices to help our members streamline their EHR implementation and obtaining the MU incentive payments in 2011.

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We applaud the subcommittee for holding this important hearing, and we support your efforts to ensure provisions of the HITECH Act are implemented correctly to ensure the goals of the act can be attained. However, as discussed above, Congress must act to ensure that hospitals with multiple inpatient facilities operating under one provider number can access appropriate Medicare and Medicaid incentive payments to deploy EHRs as Congress intended. Below is a brief description of this critical issue, which will require congressional action to rectify the problem, and existing precedence for an alternative methodology.

Multi-campus hospital issue:

Despite receiving hundreds of comments on this specific issue in response to its proposed rule published on January 13, the Centers for Medicare & Medicaid Services (CMS) chose not to make any changes to its methodology for calculating a qualifying hospital's Medicare and Medicaid EHR incentive payment. By not modifying its methodology, CMS creates an arbitrary and inequitable distinction between identical hospital systems based solely on whether a system has multiple inpatient facilities operating under a single Medicare provider number.

The final MU rule, as written, would allow only one Medicare incentive base payment per year for multiple inpatient facilities operating under the same Medicare provider number. By contrast, an identical hospital whose inpatient facilities each operate under their own Medicare provider number would receive a base payment for *each* facility. The hospital EHR incentive payment formula incorporates both a $2 million base amount and a $200 per discharge amount for the $1{,}150^{th} - 23{,}000^{th}$ discharge. Thus, the one base payment per provider number policy would significantly disadvantage multi-campus hospitals operating under a single provider number. Premier and its alliance hospitals have stated in comments to CMS that these hospitals will incur separate EHR costs for each inpatient facility and that each facility should receive a separate base payment.

This is a crucial issue for Premier alliance hospitals, and could financially handicap their ability to implement EHRs in a timely manner. More than 50 Premier alliance hospital systems representing more than 100 inpatient facilities are affected by this methodological error by CMS, which will cost them millions of dollars in EHR incentive payments.

This methodology also impacts an eligible hospital's Medicaid EHR incentive payment, as it is calculated based on the hospital's projected Medicare EHR incentive. Therefore, the multi-campus hospital would receive dramatically different Medicaid EHR incentives than another facility solely based on whether the system's inpatient facilities share a provider number or have separate provider numbers.

Existing precedent for alternative methodology:

Longstanding precedent exists to justify changing the EHR incentive payment methodology – under the Medicare wage index adjustment methodology – for multiple inpatient facilities comprising a single subsection (d) hospital to be treated as distinct entities for payment purposes under the Medicare program. The Medicare wage index methodology allows for these facilities to be treated differently in limited circumstances to account appropriately for

facility-specific costs. These same circumstances exist with respect to an EHR deployed at multiple inpatient facilities comprising a single subsection (d) hospital because each inpatient facility will incur specific EHR-related costs. CMS effectively ignores the existence of those facility-specific EHR-related costs by calculating EHR incentives as if the hospital were comprised of only a single inpatient facility.

The Premier healthcare alliance recognizes that efficient administration of the EHR incentives program requires CMS to have clear standards for Medicare and Medicaid EHR incentives. For that reason, we have been working on alternative definitions of the terms "eligible hospital" and "acute-care hospital" for purposes of identifying inpatient facilities that can qualify for their own Medicare and Medicaid EHR incentives. We would welcome the opportunity to discuss these legislative solutions with the subcommittee.

The Premier healthcare alliance appreciates the opportunity to submit this statement for the record and stands ready to work with the subcommittee to ensure the rapid implementation of EHRs and their meaningful use by providers becomes a reality. We also look forward to working with you on a legislative solution to the multi-campus hospital issue. As stated previously, Premier and its alliance hospitals are reviewing the final MU regulation and will submit additional comments for the record.

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS

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October 25, 2010

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

Dear Dr. Blumenthal:

Thank you for appearing before the Subcommittee on Health on July 27, 2010, at the hearing entitled "Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act."

Pursuant to the Committee's Rules, attached are written questions for the record directed to you from certain Members of the Committee. In preparing your answers, please address your response to the Member who submitted the questions.

Please provide your responses by November 8, 2010, to Earley Green, Chief Clerk, via e-mail to Earley.Green@mail.house.gov. Please contact Earley Green or Jennifer Berenholz at (202) 225-2927 if you have any questions.

Sincerely,

Henry A. Waxman
Chairman

Attachment

Honorable Edward J. Markey

1. Will the Department of Health and Human Services require the use of electronic consent tools that afford patients the same or stronger capacity to selectively allow disclosure of protected health information from electronic health records as to those utilized by the Clinical Management for Behavioral Health Services and the Department of Defense?

Response:

The ONC is committed to promoting patient choice in the disclosure of protected health information and is currently evaluating the maturity of the technology to facilitate such choice.

The American Recovery and Reinvestment Act of 2009 (ARRA) provided for the creation of the HIT Policy Committee (HITPC) under the auspices of the Federal Advisory Committee Act (FACA). Section 3002(b)(2)(B)(i) of the Public Health Service Act, as added by section 13101 of ARRA, requires the HITPC to submit recommendations on "[t]echnologies that protect the privacy of health information and promote security in a qualified electronic health record, including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law. . .".

To fulfill this mandate, one of the workgroups of the HITPC, the Privacy and Security Tiger Team, held a Consumer Choice Technology Hearing on June 29, 2010. At this hearing, the Department of Veterans Affairs (VA) presented on their Virtual Lifetime Electronic Record (VLER) pilots in San Diego that will employ state-of-the-art consent tools. The Clinical Management for Behavioral Health Services (CMBHS) also presented their content tool that has been used in various behavioral health facilities. The ONC assisted in the organization of and participated at this hearing and is well aware of the work regarding consent tools done in VLER, CMBHS and other organizations.

Subsequent to the Consumer Choice Technology hearing, the Tiger Team deliberated on the testimony and on the materials and demonstrations presented, and drafted its recommendations with respect to technology that affords patients the capacity to selectively permit disclosure of protected health information. These recommendations, which the HITPC considered and adopted, noted that "[t]he technology for supporting more granular patient consent is promising but is still in the early stages of development and adoption. Further experience and stimulating innovation for granular consent are needed." In accordance with this view, the HITPC recommended that ONC should make further exploration of this technology a priority, taking into account "the implications for quality of care and patient safety, patient educational needs, and operational implications" The HITPC further advised ONC to focus on real life implementations versus theoretical possibilities including tracking the development of the technology and lessons learned from the field as health information exchange matures including potentially funding pilot projects.

The HITPC's recommendations on granular consent technology were submitted to the ONC on August 19, 2010. The ONC is currently in the process of evaluating these recommendations and continues to follow the VLER project, the CMBHS and other consent technologies as they mature and are more widely adopted.

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS

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October 25, 2010

Mr. Anthony Trenkle
Director
Office of E-Health Standards and Services
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Dear Mr. Trenkle:

Thank you for appearing before the Subcommittee on Health on July 27, 2010, at the hearing entitled "Implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act."

Pursuant to the Committee's Rules, attached are written questions for the record directed to you from certain Members of the Committee. In preparing your answers, please address your response to the Member who submitted the questions.

Please provide your responses by November 8, 2010, to Earley Green, Chief Clerk, via e-mail to Earley.Green@mail.house.gov. Please contact Earley Green or Jennifer Berenholz at (202) 225-2927 if you have any questions.

Sincerely,

Henry A. Waxman
Chairman

Attachment

The Honorable Edward J. Markey

Your testimony provided a helpful update on the Centers for Medicare and Medicaid Services' implementation of the HITECH Act. Under the current eligibility criteria there is a group of physicians in my state that does not qualify for full incentive payments. These physicians treat Medicare beneficiaries under both Medicare Fee-for-Service and Medicare Advantage. These physicians are not eligible for the full incentive amount for meeting meaningful use because they do not serve a sufficient number of Fee-for-Service patients and are not part of a Medicare Advantage Organization or a hospital.

As you know, in the legislation and in the final rule by the Centers for Medicare and Medicaid Services (CMS), there are numerous exemptions or recalculations for hospitals and Medicare Advantage organizations allowing Fee-for-Service and Medicare Advantage inpatient-bed-days to be added together and converted.

1. **Does CMS have the capacity to recalculate physicians' Medicare Advantage revenue as if it were Fee-for-Service for the purposes of this incentive? If not, why not?**

Answer: CMS does not have the capacity to recalculate *all* physicians' Medicare Advantage (MA) revenue. However, based on data from qualifying MA organizations participating in the Medicare electronic health record (EHR) incentive program, as required under current law, CMS would have the capacity to calculate Medicare physician revenue for the MA organizations' affiliated eligible physicians who are "meaningful users" of certified EHR technology.

An eligible physician is considered affiliated with a MA organization when furnishing a certain number of hours of patient-care services and being employed by the qualifying MA organization; or by being employed by, or being a partner of, an entity that through contract with the qualifying MA organization furnishes a certain percentage of the entity's Medicare patient care services to enrollees of the qualifying MA organization. To calculate the incentive payments to a qualifying MA organization, our final rule (CMS-0033-F, FR 75/144 – July 28, 2010) identifies the way the MA organization will be required to report the annual aggregate Part B revenue attributable to professional services provided to MA enrollees by the MA organization's eligible physicians who are "meaningful users."

In response to section 4101(d) of the American Recovery and Reinvestment Act of 2009, the Department of Health and Human Services submitted a Report to Congress on February 5, 2010, discussing the possibility of EHR incentive payments to "nearly-exclusive" MA physicians. We concluded that while making such payment would be logistically feasible if such physicians attested directly to CMS, it would be challenging to do so and would be even more challenging to impose payment adjustments with respect to such physicians. We recommended other options for encouraging EHR adoption by "nearly-exclusive" MA physicians, including relying on resources offered by

regional extension centers, and encouraging such physicians to change their patient case mix to include more Medicaid or original FFS Medicare enrollees.

2. **Why is CMS able to recalculate the inpatient-bed-days for hospitals and Medicare Advanced organizations, but not create a similar recalculation for non-hospital, non-Medicare Organization physicians?**

Answer: All MA-affiliated hospitals must have CMS provider agreements and must submit annual cost reports – as do all other Medicare certified hospitals. Therefore, CMS possesses the data necessary to calculate inpatient-bed-days/discharges that include both Medicare FFS and MA patient for individual hospitals. However, CMS does not have data on the actual payments made to individual physicians by MA organizations.

3. **If CMS needs additional information about physicians who treat Medicare Advantage patients to make these recalculations, please specify what information is needed. If the required data is not available, what steps has CMS taken or will CMS take to gather the necessary information?**

Answer: As indicated in prior responses, we will have qualifying MAOs provide physician compensation information so we can calculate the MA EHR incentive payment due to such organizations for qualifying MA EPs. Beginning in 2015, with respect to each qualifying MA organization for their affiliated eligible physicians who are not "meaningful users," we will need to know the proportion of non-eligible MA EPs compared to eligible MA EPs in order to calculate the adjustments.

4. **If Congress passed, and the President signed into law, legislation recalculating Medicare Advantage revenue into Fee-for-Service dollars for non-hospital, non-Medicare Advantage Organization providers how long would it take for HHS to implement the law?**

Answer: The timing for implementing legislative changes would depend on several key factors: 1) when the legislation became law (for instance, potential need to align EHR incentive payments with the MA payment cycle), 2) the method Congress proposed to recalculate Medicare Advantage revenue into Fee-for-Service dollars for non-hospital, non-Medicare Advantage Organization providers in order to make them eligible for this incentive, and 3) data collection that would be needed for incentive payments and adjustments.

Depending on the nature of the legislation, CMS could potentially be required to go through rule making to establish the implementation of incentive payments and adjustments to these physicians. Generally speaking, the rule making process would take a minimum of 18 months.

Additionally, if such legislation required CMS to use MA organization generated physician data to pay and adjust payments for these physicians, it would likely require this initiative to be aligned with the MA payment cycle, which is based on a contract year

that begins January 1. By law, CMS cannot impose new requirements on MA organizations mid-year. CMS must initially notify MA organizations of changes for the coming calendar year by mid-February of the prior year. This timeline must be adhered to so organizations can bid in June, plan contracts can be signed in September, plans can begin marketing in October, and beneficiaries have the opportunity to make a plan election in the Fall. In this way beneficiaries' health coverage can become effective on January 1st without interruption.

All of these factors would impact the time it would take to implement a Congressional mandate requiring CMS to recalculate Medicare Advantage revenue into Fee-for-Service dollars for non-hospital, non-Medicare Advantage Organization providers in order to make them eligible for this incentive.

5. **If the eligibility criteria for meaningful use were revised to include these providers after the January 1, 2011 start date for early adopters, and these providers met all other meaningful use requirements by January 1, 2011, does CMS have the capacity to retroactively evaluate the eligibility of providers for the early adopter incentives and distribute those incentives? If not, what additional resources would be required to perform this evaluation and distribution?**

Answer: In addition to the contingences and timing considerations noted in the previous question, the need for additional resources would depend on the manner in which Congress would establish meaningful use criteria for such providers and direct CMS to implement any new legislation. We note that a provider must demonstrate meaningful use in any 90-day period within 2011 (as specified in 42 CFR §495.4 – definition of *EHR reporting period*) in order to receive incentive payments in 2011.

The Honorable John Shimkus

1. **Given that the majority of rural hospitals are situated many miles from other hospitals and knowing that vendors do not have sufficient numbers of trained professionals to service all of their potential customers, will there be any extension of deadlines for rural hospitals that do not meet the deadlines due to lack of vendor resources to service them?**

Answer: The timelines established by the American Recovery and Reinvestment Act (Recovery Act) do not permit deadline extensions for providers. Thus, an eligible hospital would need to begin to participate in the Medicare EHR incentive program by fiscal year 2013 to earn the maximum incentives over four years. Eligible hospitals have until fiscal year 2016 to begin participation in the Medicaid incentive program. Sections 1814(l)(4)(C) and 1886(b)(3)(B)(ix)(II) of the Social Security Act, as added by section 4102(b) of the Recovery Act, allow the Secretary of Health & Human Services, on a case-by-case basis, to exempt eligible subsection (d) hospitals and critical access hospitals (CAHs) from the payment adjustments imposed by the Medicare EHR Incentive Program if the Secretary determines, subject to annual renewal, that requiring these hospitals to be meaningful EHR users beginning in FY 2015 would result in a significant hardship, such as in the case of rural hospitals without sufficient Internet access. However, this provision of the Recovery Act does not allow us to grant an exemption for more than 5 years.

CMS understands the special challenges faced by many rural hospitals. We attempted to provide flexibility in the Medicare and Medicaid EHR Incentive Programs by allowing all eligible hospitals and critical access hospitals (CAHs) to choose when they begin participation in the program. Under current regulations, eligible hospitals can begin participating as late as July 2013 and still receive the maximum incentive payments possible. Current regulations limit the reporting period in the first participation year to 90 continuous days in order to reduce the burden associated with the implementation and meaningful use of certified EHR technology. In addition, for payment years 2011 and 2012, we lowered the thresholds for many of the meaningful use objectives, provided a number of appropriate exclusions for objectives, and even allowed hospitals to defer 5 objectives from the menu set. We believe the timeline of the program and the flexibility of exclusions and menu set objectives will allow rural hospitals adequate time to reach the targets for all of the meaningful use objectives and qualify for the full EHR incentive payments.

2. **Given that many rural hospitals have difficulty in securing financing for the initial investment for EHR, are there any federal grant programs that will be made available?**

Answer: In addition to incentive payments available to Medicare eligible subsection (d) hospitals that are able to demonstrate meaningful use, the statute allows Critical Access Hospitals (CAHs) to receive Medicare incentive payments for the reasonable costs incurred for the purchase of certified EHR technology, excluding any depreciation and

interest expenses associated with the initial acquisition. Additionally, in response to public comments on the proposed rule, CMS added CAHs to the definition of a Medicaid acute care hospital, so that CAHs may qualify for both programs.

3. **Given that several hospitals have built EHRs based upon components from different systems, what happens if one or more components of a multi-vendor EHR system do not meet meaningful use, but the majority of system components are certified, how will CMS 'score' the hospital in terms of meeting meaningful use? Typically these multi-vendor systems are found in rural and Medicaid safety net hospitals.**

Answer: Under the Medicare and Medicaid EHR Incentive Programs, eligible providers must successfully demonstrate meaningful use with "Certified EHR Technology," which means that all the components used to meet the meaningful use objectives must be certified according to the standards adopted by HHS. Hospitals with multiple components will need to have each of the modules certified by an HHS Office of the National Coordinator for Health Information Technology (ONC) Authorized Testing and Certification Body (ONC-ATCB) and then assess the components they possess to determine that the combination of certified EHR Modules includes capabilities that meet all applicable adopted certification criteria. If a hospital's multi-component EHR system does not include all of the capabilities of the applicable adopted certification criteria, the hospital will not be eligible for an EHR incentive payment.

It is our hope that the significant incentive payments provided to rural hospitals through the Medicare and Medicaid EHR Incentive Programs will help alleviate the cost of certifying existing EHR components and adopting new, certified EHR components that will help those hospitals successfully demonstrate meaningful use.

4. **Illinois, like many other states, has multi-hospital systems that operate within and across state boundaries. While multi-hospital systems that have multiple Medicare ID numbers receive incentive payments for each of their hospitals, multi-hospital systems with one single Medicare ID number issued by CMS only receive one incentive payment and are treated as one hospital. Will this situation be corrected so that multi-hospital systems that have been assigned one Medicare ID number for their entire system hospitals receive incentives for each of their hospitals that meet meaningful use?**

Answer: Hospitals have flexibility in deciding how to organize themselves. Once a hospital has chosen to organize itself as a single entity under one Medicare number, CMS will recognize that hospital as a single entity, for all purposes, including EHR incentive payments. This is consistent with all other CMS programs including Disproportionate Share Hospitals and Graduate Medical Education. In the absence of legislative direction to do otherwise, CMS will continue to treat each hospital organized under a single Medicare number as a single entity for the purposes of EHR incentive payments.

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