

Congress Should Fix Rule And Make HIT Incentive Payments Available To All Hospitals

By Rep. Michael C. Burgess, M.D. (R-TX)

The American Recovery and Reinvestment Act of 2009 (H.R. 1), signed into law by President Obama on February 17, 2009, contained a provision providing financial incentives to hospitals and other health care providers considered to be “meaningful users” of certified electronic health records (EHRs).

Recently, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to implement the financial incentives provision by defining “meaningful users” of certified EHRs. Unfortunately the rule prevents certain hospitals from receiving a full EHR incentive payment, making it more difficult for some hospitals to adopt EHR technology.

CMS’s rule states that EHR incentive payments should be distributed to hospitals based upon hospitals’ Medicare provider number, instead of individual hospital campuses. This creates a glaring inequality between single-campus hospitals and hospitals that are part of a multi-campus system.

In many systems, a single provider number can include multiple campuses of a hospital system. For hospital systems with multiple hospital campuses under the same Medicare provider number, this regulation means a significant reduction in incentive payments that will make the purchase and development of required health information technology (HIT) systems more difficult.

Multi-campus hospital systems already face unique challenges with regard to acquisition, training and implementation. These barriers, coupled with insufficient funds, are crippling to systems that provide care to so many Americans.

I, along with Ohio Democrat Congressman Zach Space, have introduced the “Electronic Health Record Incentives for Multi-Campus Hospitals Act of 2010” (H.R. 6072), which would remedy this disparity. This legislation has bipartisan support from more than 50 cosponsors, as well as the Federation of American Hospitals and the American Hospital Association.

This legislation will address the disparity in the rule, which could cost some hospitals millions of dollars in incentive payments. For many hospital systems, the lack of these funds may serve as a barrier to the adoption of EHRs.

Specifically, the legislation would ensure that Medicare and Medicaid incentive payments are available to all hospitals in multi-campus systems that meet meaningful use requirements. These hospitals could choose the appropriate payment method for their institutions and communities, either through additional base payments or additional per-discharge amounts.

As a doctor, patient safety always is my top concern, and I see technological developments in hospitals as a path to reduce errors due to burdensome paper charts. I never will forget visiting a hospital in New Orleans right after Hurricane Katrina, and seeing thousands of paper medical records, which were stored in the hospital’s basement, ruined by the floodwaters.

Through the implementation of HIT, hospitals will be able to use EHRs to better monitor patients, gain instant access to medical histories and charts, and equip doctors with the ability to make lifesaving decisions accurately and quickly. It is ridiculous for CMS to provide such narrow requirements for hospitals to be eligible for the full incentive payment for technology that will save lives. In my home state of Texas there are multiple hospitals that will be adversely affected by this provision.

The technology is there, but unfortunately this onerous rule that came out of CMS either may prevent or postpone adoption of HIT. I am encouraged by what I have seen and heard from hospital systems all across the country, and hopeful that this bipartisan effort will be passed into law and yield significant results that not only are beneficial for hospitals, but for patients as well.

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Rep. Burgess, a physician, is a Member of the House Committee on Energy and Commerce and its Subcommittee on Health. He also founded and currently serves as Chairman of the Congressional Health Care Caucus.