October 4, 2012

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

Dear Secretary Sebelius:

We are writing to express serious concerns about the final Electronic Health Record (EHR) Stage 2 Meaningful Use program rules recently issued by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC). We believe that the Stage 2 rules are, in some respects, weaker than the proposed Stage 1 regulations released in 2009. The result will be a less efficient system that squanders taxpayer dollars and does little, if anything, to improve outcomes for Medicare.

For example, proposed Stage 1 proposed rules set electronic prescribing and medication reconciliation compliance thresholds at 75 percent and 80 percent, respectively, while the final Stage 2 rules set this threshold at just 50 percent. This is but one example of how the Stage 2 rules ask less of providers and do less for program efficiency.

In 2009, when the so-called stimulus law was being debated in Congress, Republicans expressed support for efforts to achieve interoperable health information technology systems. However, we warned that failure to set a date certain for interoperable standards would put as much as $35 billion in Medicare and taxpayer funds in the hands of providers who purchase and use EHR systems that are not interoperable. The Stage 2 rules fail to achieve comprehensive interoperability in a timely manner, leaving our health care system trapped in information silos, much like it was before the incentive payments. The Stage 1 final rules required providers to test the ability to exchange information with other providers, while Stage 2 eliminates this requirement for Stage 1. As a result, hospitals and physicians who are deemed Stage 1 "meaningful users" are not required to know with certainty whether their systems are capable of exchanging information. More than four and a half years and two final Meaningful Use rules later, it is safe to say that we are no closer to interoperability in spite of the nearly $10 billion spent.

Perhaps not surprisingly, your EHR incentive program appears to be doing more harm than good. A recent analysis of Medicare data by the *New York Times* explains the costly consequences:

> "The move to electronic health records may be contributing to billions of dollars in higher costs for Medicare, private insurers and patients by making it easier for hospitals and physicians to bill more for their services, whether or not they provide additional care. Hospitals received $1 billion more in Medicare reimbursements in 2010 than they did five years earlier, at least in part by changing the billing codes they assign to patients in emergency rooms. ...Regulators say physicians have changed the way they bill for office visits similarly, increasing their payments by billions of dollars as well."

As you know, the American Hospital Association blamed the spike in Medicare spending, in part, on a lack of clarity related to billing for services performed in emergency departments and clinics. This association believes that the Current Procedural Terminology coding system does not meet the needs of hospital providers. If this is indeed the case, CMS should consider developing an alternative coding system that is applicable to care delivered in these settings.

We urge you to rethink your strategy related to Meaningful Use criteria and instead focus on the stated goal of making health care delivery more efficient and affordable. Continuing down the current path will further exacerbate Medicare's looming bankruptcy, create demand for billions of dollars in additional incentive payments once interoperability standards are finally put in place, and further frustrate providers. It is highly counterproductive for providers to have purchased EHR systems that cannot "talk with one another" and cannot perform basic functions because of the insufficient standards set by your agency. You are missing an opportunity to reduce duplicative, unnecessary, and even harmful care.
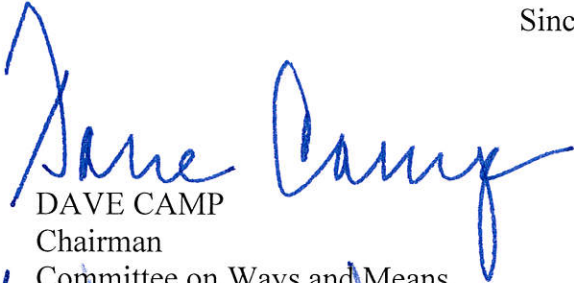
Specifically, we urge you to:

- Immediately suspend the distribution of incentive payments until your agency promulgates universal interoperable standards. Such a move would also require a commensurate delay of penalties for providers who choose not to integrate HIT into their practice.

- Significantly increase what's expected of Meaningful Users. For example, requiring a summary transfer when a patient moves to a different care setting in electronic format only 10 percent of the time is insufficient. Further, only requiring radiology and laboratory orders to be electronic 30 percent of the time and medication reconciliation and electronic prescribing to occur just 50 percent of the time is woefully inadequate.

- Take steps to eliminate the subsidization of business practices that block the exchange of information between providers.

With the bar for Meaningful Use set so low, and with a focus instead on trying to pad participation rates, these challenges are predictable. Incentive payments, particularly those funded by the Medicare trust funds and taxpayers, should be given to providers who are truly "meaningful users" of EHR.

We strongly urge you to change the course of direction of the Meaningful Use incentive program. It is critical that your agency do everything possible to advance interoperability and meaningful use of HIT, not just in name only. We look forward to continuing to work with you to strengthen the Medicare program while ensuring beneficiary and taxpayer investments in information technology are maximized.
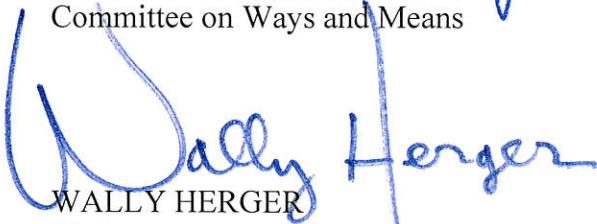
Sincerely,

DAVE CAMP
Chairman
Committee on Ways and Means

FRED UPTON
Chairman
Committee on Energy and Commerce

WALLY HERGER
Chairman
Committee on Ways and Means
Subcommittee on Health

JOE PITTS
Chairman
Committee on Energy and Commerce
Subcommittee on Health

cc: Marilyn Tavenner, Acting Administrator, CMS
Farzad Mostashari, National Coordinator for Health Information Technology