

October 6, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Inclusion of ASC encounters in calculating eligibility for the HITECH EHR Incentive Program

Dear Dr. Berwick:

On behalf of the Ambulatory Surgery Center Association (ASCA), representing the interests of the nation's 5,300 ASCs, I am writing to express concern over the current policy of including ambulatory surgical center (ASC) patient encounters in calculating whether a physician is a "meaningful user" of electronic health records (EHR) under the HITECH EHR incentive/penalty program. As currently constructed, the policy unfairly penalizes physicians who treat a large number of patients at ASCs and may lead to the limitation of patient choice, as well as delayed and more costly care.

Among other requirements, in order for a physician to be a meaningful EHR user "at least 50 percent of [the physician's] patient encounters . . . must occur at a practice/location or practice/locations equipped with certified EHR technology."¹ In the final rule implementing this requirement, there is no indication that an ASC is considered a "practice or location" within the meaning of this definition.² However, in Medicare's Frequently Asked Questions about the final rule, CMS makes it clear that patient encounters in ambulatory surgery centers "should be included in the denominator of the calculation" of whether a physician has at least 50 percent of his or her encounters in a place equipped with a certified EHR.³

The HITECH Act, passed as part of the American Recovery and Reinvestment Act of 2009 (PL 211-5), provides for incentive payments to physician practices and hospitals that implement a certified EHR. ASCs, however, are not eligible for these incentive payments and therefore would have to bear the full costs of purchasing and installing the EHR system.

Additionally, because ASCs are not included as eligible recipients, the standards regarding what constitutes a "certified EHR" were written without the unique information technology needs of ASCs in mind. For instance, one of the certification standards is that the system be able to allow users "to electronically record, store, retrieve and modify, at a minimum, the following order types: (1) Medications, (2) Laboratory; and (3) Radiology/imaging."⁴ While such a requirement makes sense in the hospital and physician office setting where such items are routinely ordered, it does not make sense in the majority of ASC settings where such items are never ordered. Since the entire certification regime

¹ 42 CFR 495.4

² 75 FR 44329 (July 28, 2010)

³ Medicare FAQ Answer ID 10466, https://questions.cms.hhs.gov/app/answers/detail/a_id/10466/p/21%2C26%2C1139

⁴ 42 CFR 170.306(a)

was established without ASCs in mind, it is simply not practical for ASCs to comply with the requirements.

By including patient encounters in ASCs in the denominator of the 50% threshold calculation, physicians will be punished for treating patients at ASCs because these physicians will be at significant risk of not having a sufficient number of encounters in a setting equipped with a certified EHR. This risk is most pronounced in situations where a specialist does not see a patient in their office prior to treatment at an ASC.

For example, CMS considers preoperative evaluations in the gastroenterologist's office to be incidental to any subsequent procedure performed in an ASC and are therefore not separately payable. This CMS policy has resulted in many gastroenterologists modifying their work flows and practices. To achieve greater efficiency and enhanced productivity, preoperative evaluations now routinely take place in the ASC where the procedure will be performed. The result is that when a patient needs a procedure such as a colorectal cancer screening, the patient is treated in an ASC without first going to a gastroenterologist's practice. In this scenario, it would be difficult for the gastroenterologist to meet the 50% threshold necessary to be considered a meaningful user.

Faced with the possibility of penalties, physicians will likely choose to treat more patients at a hospital outpatient department (HOPD). Additionally, it could lead to physicians unnecessarily performing preoperative evaluations in their offices when they could be done more efficiently at the ASC on the day of the procedure.

Given the rising costs of health care facing the nation, this is exactly the wrong incentive to have in place. Every time a patient is treated in an HOPD instead of an ASC, it costs Medicare and patients 75% more. Further, it may result in delays in patients receiving care due to scheduling constraints at the hospital.

Accordingly, CMS should issue guidance to clarify that ASCs are not considered locations under the rule for calculating the attainment of meaningful use. Alternatively, CMS could define "patient encounters," a term that remains undefined, to exclude services provided at ASCs.

Thank you for the opportunity to offer these comments. We welcome a meeting with CMS staff to discuss our concerns and recommendations. If ASCA may provide any additional information, or to set up a meeting with representatives of the ASC community, please contact Jonathan Beal at jbeal@ascassociation.org or 202.487.0941.

Sincerely,



William Prentice
Executive Director
Ambulatory Surgery Center Association