



Clarification of Recent Mischaracterizations of H.R. 1

The HIT provisions in H.R. 1 would not create a federal system for electronically tracking medical treatment. H.R. 1 would authorize the existing Office of the National Coordinator for Health Information Technology (ONCHIT) to promote the development of a national HIT infrastructure to allow for the electronic use and exchange of information to improve health care quality, reduce health care costs, improve public health, facilitate research, and so forth. The bill also establishes HIT Policy and Standards Committees that are comprised of public and private stakeholders. These Committees would make recommendations to ONCHIT on policy, implementation, standards, and certification criteria for electronic exchange and use of health information. Any standard or implementation specification endorsed by ONCHIT is voluntary with respect to private entities.

The HIT provisions do not create a new bureaucracy with sweeping authority. The HIT provisions in H.R. 1 call for building on existing federal efforts to encourage HIT adoption and use by codifying ONCHIT within the Department of Health and Human Services (HHS). President George W. Bush created ONCHIT by Executive Order in 2004, and it was charged with developing and implementing a strategic plan to guide widespread adoption and use of HIT by health care providers.

The HIT penalty provisions are not related to treatment decisions. In order to encourage health care providers to adopt and use qualifying electronic health record systems (EHRs) that allow the electronic use and exchange of health information in a secure manner, H.R. 1 provides incentive payments to physicians and hospitals under the Medicare and Medicaid programs to encourage them to adopt and use EHRs in a meaningful way (as defined by the Secretary of HHS). Eligible physicians and hospitals that do not adopt/use a qualifying EHR by 2016 (House bill) or 2015 (Senate bill) would face reductions in their Medicare fee schedule payments. Both bills allow significant hardship exceptions to penalties, as determined by the Secretary of HHS.

The Clinical Effectiveness Research (CER) funded by H.R. 1 will not include recommendations or mandate national clinical guidelines or coverage. Both the House and Senate version of H.R. 1 incorporate by reference the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act that **prohibit** the Secretary of HHS from including mandates establishing national clinical guidelines and/or national coverage decisions in CER.

The proposed CER Advisory Coordinating Council would not be responsible for establishing national coverage determinations, national clinical guidelines, or making recommendations or establishing directives based on cost-effectiveness. The Advisory Council is responsible for coordinating CER to avoid duplication of agency research and to make recommendations to the Secretary of HHS on infrastructure needs to support CER.

The Advisory Council would have neither the breadth nor scope of authority or responsibilities held by the United Kingdom's National Institute of Clinical Excellence (NICE). Nor would the Coordinating Council have the wide-ranging authority or responsibilities of a centralized Federal Health Board. In sharp contrast, the Advisory Council proposed in H.R. 1 would have a very limited scope, with no authority beyond coordinating research and making recommendations to the Secretary. The most controversial issues, such as national guidelines and national coverage mandates, are beyond the authority of the Advisory Council.

The Senate version of the bill clarifies that additional CER funding will support comparative clinical effectiveness research. Even if the House report language mentioning costs survives Senate and House negotiations, the above analysis remains the same. The Advisory Council would remain unable to establish national clinical guidelines or mandate coverage.